Annex A

Isle of Wight NHS
NHS Trust

Hospital Ambulance Community Mental Health

Isle of Wight NHS Trust

Quality Account 2012/13









Quality Care
NHS
everyone everytime

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PART 1

Chairman's and Chief Executive's Statement on Quality

It gives me great pleasure to introduce the Isle of Wight's NHS Trust second Quality Account, designed to assure commissioners, patients and our local population that we provide the highest level of clinical care and continuously seek to improve what we do.

This Quality Account has been developed with internal and external stakeholders and partner organisations, including clinicians and senior managers, commissioners from the Isle of Wight Clinical Commissioning Group (CCG), Local Authority and the Scrutiny Board for health and Wellbeing. This Quality Account has been approved by the Trust Board.

This report focuses on year 2012/13, tracking our progress over the past year against a number of quality improvements and outlining our priorities for the year ahead. It is an open and honest account of the quality of services for which the Trust Board is accountable. Although there has clearly been significant improvement, the Board remain dissatisfied with the current levels of patients developing Healthcare Acquired Pressure Ulcers (bed sores), and are therefore pleased to see this committed to the 2013/14 Quality Goals.

The Trust Board is committed to the delivery of effective, safe and personal healthcare to every patient, every time. This is underpinned by the Trust strategic goals, which are applied by all staff working at the Trust.

Our Vision & Values

Quality Care for everyone, every time is our guiding principle. Our vision is 'to be an excellent and trusted provider of integrated patient focused services that are globally admired'. We will pursue greater integration – internally and with primary and social care – with a focus on the patient. Our strategic objectives are to:

1. Improve quality – by not only ensuring the results of treatment and care (outcomes) are as good as the best achieved elsewhere; but by making sure our patients feel (and say) we are treating them with compassion and dignity.

2. Deliver our integrated clinical strategy – ensuring the various services we offer in hospital and in the community work closely together, so that care is provided as locally and smoothly as possible; and ensuring our services are always organised to be safe and secure.

3. Improve our resilience (as an isolated provider) – by working with others, such as GPs, other NHS providers, the Council, local charities and the private sector, we will build on strengths and overcome the potential weaknesses of being a small and geographically isolated provider.

4. Improve productivity – ensuring we run as efficiently as possible, so that taxpayers' money is spent as it should be – on improving patient care.

5. Develop our workforce – ensuring we develop our staff to have the skills to work flexibly across the Island, and to be ready for the challenges of working in tomorrow's NHS.

The work described in this report builds on two key strategies:

1. Integrated Business Plan 2012

2. Quality Improvement Plan 2012

Our Quality Strategy is supported by a long-term quality plan that explains our priorities and ambitions over the next 5 years, taking us to 2018/2019. Assurance that we are making the right process will be provided through our Quality and Clinical Performance Committee (the sub group of the Trust Board established in 2012).

In 2012/13 we made good progress with our patient safety programme. In particular we have reduced the Hospital Standard Mortality Ratio from 124 to 107. This moved the Trust from a position of a national outlier to one which lies within the acceptable range. We have maintained this position over the last 12 months. Rates of infection in hospital and the community, particularly those for MRSA, have also reduced significantly over the last 12 months.

To improve our focus on quality and safety in 2012/13, we have worked directly with our patients to learn more about their experiences. The Trust board continued to undertake Board to Ward Assurance Visits increasing their frequency to weekly in 2013. This has provided an opportunity for Trust Board members to meet patients, their relatives, and the dedicated staff who care for them. These opportunities provide an ideal opportunity for the Board to hear first hand their experiences and discuss concerns and priorities for improvement.

This year we have also worked closely with clinicians and staff to improve the quality of services delivered. Following a detailed listening event "The Big Discussion" in September 2012 we have introduced a number of measures to increase the involvement and participation of senior Doctors and Nurses in our change management programmes. This has resulted in our support structures being more closely aligned to patient services including the Integrated Services Information System (ISIS) IT Programme and Human Resource (HR) Recruitment processes to ensure we continue to attract the highest skilled staff available. We also took the decision to move the support functions of Portering, Cleanliness, Catering and Medical Equipment to the Executive Director of Nursing & Workforce. This ensures the services are led and delivered as near to the patient as possible. Gaining real time feedback from patients and staff will provide us with the opportunity to respond to concerns quickly.

We have continued to work in close partnership with the Care Quality Commission (CQC), the official body that monitors whether the Trust meets essential quality and safety standards. Throughout the year we received 3 visits from the CQC, including a routine compliance inspection at St. Mary's Hospital in January 2013. The CQC judged that we were meeting all of the essential standards assessed. These visits are carried out periodically. The Trust welcomes all forms of assessment as a means to confirm we are getting things right for patients and staff. In addition to the CQC visits, the Trust has been contacted on a number of occasions by the Local Involvement Network (LINk) now known as Healthwatch. On the whole these have been positive; however, the Link assessments have provided the Trust with additional areas to focus on. We value this external scrutiny and will use the outputs from such visits to shape our priorities for 2013/14.

Our ambitions to become a Foundation Trust place Quality at the very centre of all our decision making. To support the changes to be, foremost, a successful organisation we continue to deliver a comprehensive programme of transformation with partners in the Clinical Commissioning Group and Social Care. This has allowed patients to receive treatment and care in the most appropriate setting for their needs including, where possible, care closer to home. The ambition to continue this work is realised by patients and providers, and with the development of the "My life a Full Life" project, we hope to see this vision go from strength

to strength. This is a programme of work to integrate care and support for adults on the Isle of Wight, through better communication and sharing of information between organisations and with the people for whom support and services are provided.

2013/14 offers the Isle of Wight NHS Trust a range of challenges. We have made significant progress in many areas, and plan to continue with the same level of enthusiasm in 2013/14. Our staff remain fully committed to the provision of safe and effective care for all our patients and we look forward to making further improvements in 2013/14 and our initiatives are aimed at reducing the number of complaints we receive. Our plans and priorities are all explained further in this account and our progress will continue to be overseen and supported by the Trust.



Karen Baker
Chief Executive

Danny Fisher
Chairman



PART 2

2.1 Priorities for Improvement

2.1.1 Key Priorities for Action 2013/14

The Isle of Wight NHS Trust Board in consultation with key stakeholders has identified 4 overarching priorities for quality improvement during 2013/14. These priorities are derived from the performance over the past year against quality and safety indicators; national and regional priorities and are outlined here in more detail. The priorities include aspects from across the organisations to reflect the complexity of the Isle of Wight NHS Trust and include aspects of patient safety, clinical effectiveness and patient experience. Progress against all priorities will be reported to the Board via the monthly performance report (quality section) and monitored via the Quality & Clinical Performance Committee.

If patients are to benefit from the priorities set by the Trust, staff need to believe the priorities will bring about an overall improvement to all patients in all areas of the organisation. It was therefore very important for the Board to receive direct feedback from staff patients and stakeholders. A wide range of stakeholder consultation has been undertaken prior to the development of the 2013 Quality Account, including a patient experience event in November 2012 and via the use of a Survey Monkey questionnaire, to support the identification of priorities for the coming year. The results of these have revealed the Quality Priorities as we move forward to 2013/14.

A full list of key stakeholders engaged in the development of this Quality Account can be found in Appendix 1.

2.1.2 PRIORITY 1: Reducing Mortality Rates (Clinical Effectiveness)

The organisation was identified in the autumn of 2011 to have a Hospital Standardised Mortality Ratio (HSMR) of 124 and a Standardised Hospital Mortality Index (SHMI) of 118.9 for the year 2010/11, the second worst in the country. The organisation committed in the organisation's 2011/12 Quality Account to reduce the HSMR figure to below 110 and to see a downward trend for the SHMI. Over the past 18 months the organisation has made significant improvements in this area resulting in a HSMR of 101 for the period April 2012 to March 2013 (rebased at 107) and SHMI of 1.0609 for the period October 2011 to September 2012.

In 2013/2014 the organisation will continue to build on its Mortality Action plan to further drive through improvements in clinical care and in the quality of its clinical coding. 2012/13 community deaths were coded from notes and in 2013/14 the organisation will work to improving coding for all inpatients. Developments in how clinical teams are utilising the Dr Foster tools to identify areas to improve clinical practice along with enhanced use of benchmarking data for clinical specialties will further continue to provide areas where the organisation can improve its care. A new Quality Dashboard will be available from June 2013 and the Critical Care Outreach team will be embedded as a 7 day a week service.

Key performance indicators for 2013/2014

Measure	Data Source	Frequency	Data collected and reported by
Number of in hospital deaths	Flash Report	Weekly	Executive Medical Director
SHMI	NHS Information Centre	Quarterly	Executive Medical Director
HSMR	Dr Foster analysis tools	Monthly	Executive Medical Director

2.1.3 PRIORITY 2: Prevention of Pressure Ulcers (Patient Safety)

Pressure ulceration (commonly called bed sores) are distressing and painful wounds that patients sometimes experience, due to immobility, poor skin condition and / or other medical conditions which make them vulnerable.

In the organisation's 2011/2012 Quality Account it set a clear priority to undertake further work to embed the zero tolerance approach to healthcare acquired pressure ulcers particularly those developing in patients whilst they are in hospital or in the care of the district nursing service.

The Isle of Wight NHS Trust recognises how important pressure ulcers are in highlighting the standards of care that are achieved across all settings and have continued to focus over the last four years on reducing the occurrence of these ulcers, but agree there is more work that needs to be undertaken; which concurs with the feedback from stakeholders on suggested priority goals for this year. This has informed the decision to keep prevention of pressure ulcers as one of the Trust's key quality priorities for 2013/14. The key indicators chosen this year differ slightly from those included in the previous three Quality Accounts, as they will focus on reporting individual numbers of ulcers, rather than reporting performance as a percentage of patients admitted or discharged. The Trust has adopted and continues to use the European Pressure Ulcer Advisory Panel's four stage grading tool for pressure ulceration, as recommended by the NICE guidelines for Pressure Ulcers (CG29).

The Nutrition and Tissue Viability Service are committed to supporting good quality care; planning and documentation as part of ward visits. The service has also developed competency standards relating to pressure ulcer prevention and management. Competence assessments provide reassurance to the public receiving care from our clinicians that they are capable of providing safe and effective care in this area. The aim is to roll out the Competency Assessments to all trained Nurses within the first quarter of this current year. The Nutrition and Tissue Viability Service will continue to support ward and community areas in their reporting and review of pressure ulcer care, and in the delivery of key educational outcomes which will support their high quality care.



Key performance indicators for 2013/2014

Measure	Data Source	Frequency	Data collected and reported by
Hospital setting			
Zero grade 4 pressure ulcers in the hospital setting	Datixweb incident reporting system	Monthly	Nutrition and Tissue Viability Service
50% reduction in pressure ulcers of grade 2 and 3 on 2012-2013 baseline*	Datixweb incident reporting system	Monthly	Nutrition and Tissue Viability Service
Community setting			
50% reduction in pressure ulcers of grade 2, 3 and 4 in community setting, measured against 2012-2013 baseline*	Datixweb incident reporting system	Monthly	Nutrition and Tissue Viability Service

*2012-2013 baseline

Hospital	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Grade 2	12	7	1	13	11	6	5	11	6	9	13	9	103
Grade 3	3	0	0	0	2	0	5	0	1	2	2	2	17
Grade 4	0	0	4	1	2	2	2	2	4	2	2	1	22

Community	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Grade 2	8	10	14	14	9	9	14	6	12	8	11	11	126
Grade 3	1	4	3	2	4	5	4	3	2	1	4	3	36
Grade 4	0	0	0	1	3	0	3	2	1	0	4	4	18

2.1.4 PRIORITY 3: Improving Communication (Patient Experience)

The organisation's Communication and Engagement Strategy 2010 – 2013 states that 'the way in which the organisation engages with its many stakeholders, communicates with them and involves them will have a large bearing on its success.' The overall aim of this Strategy is to develop and use excellent communications and engagement activity to support delivery of the aims and objectives of the organisation and promote meaningful and productive engagement with stakeholders.

Over the last twelve months, the Isle of Wight NHS Trust has received a number of complaints and concerns relating to poor communication or a lack of communication. Examples of some of these are outlined in the table below:

Examples of Complaints & Concerns relating to Communication – 2012/2013
Incorrect information on discharge summary.
Lack of communication with relative about procedure.
Poor communication about medication.
Poor communication about patient's treatment plan, ward staff unhelpful.
Delay in providing information to the GP and patient.
Concern regarding the lack of information in relation to care and treatment.
Relatives given incorrect information.
Appointment letter did not specify where clinic was to be held.
Poor communication and failure to keep patient informed.
Poor planning and communication led to procedure not going ahead.
Delay in information being relayed.
Insufficient information about after care.

In order to obtain feedback from service users, the Isle of Wight NHS Trust held a Patient Experience event in November 2012, providing patients; carers and relatives with a face to face opportunity to give feedback on their experiences, both positive and negative. Following analysis of the feedback received at the event, the main area of concern related to a lack of communication between staff; patients; carers and relatives.

Patients Experience Event – Examples of Feedback
Quality of care is compromised by lack of time for talking to patients – all staff appear to be very rushed – not their fault – staff shortages.
Communication needs to be improved, particularly in the waiting period before action is taken, for example waiting for a Doctor. It would be useful if there was a system by which staff were prompted, once an hour or so, to let patients who are in bed know what is happening e.g. any delay.
Not sharing information between services; where patients have more than one medical condition.
Difficulty finding people to talk to; Matron not visible on ward – would be able to solve problems on ward as they happen.

Through the accumulation of feedback from various sources, including the patient experience event; complaints; concerns and the recent survey on quality goals, there is clearly more work that the organisation needs to undertake if it is to improve communication between itself; patients; carers and relatives. This issue needs to be addressed as part of an organisational wide approach.

Work is currently underway in raising staff awareness through area specific action plans in relation to complaints and development days for staff. The Trust is also keen to work in partnership with key external stakeholders, such as the local Healthwatch in driving forward improvements.

The NHS Constitution (2013) states that "we earn the trust placed in us by insisting on quality and striving to get the basics of quality of care – safety, effectiveness and patient experience – right every time. We encourage and welcome feedback from patients, families, carers, staff and the public. We use this to improve the care we provide and build on our successes."

The Isle of Wight NHS Trust supports this value and has, therefore, taken a decision that improving communication must be one of the organisation's key quality priorities for 2013/14 and will measure progress against the following key performance indicators:

Key performance indicators for 2013/2014

Measure	Data Source	Frequency	Data collected and reported by
Reduction in number of complaints relating to communication	DATIX	Monthly	Quality Team
Reduction in number of concerns relating to communication	DATIX	Monthly	Quality Team

The above key performance indicators will be measured against the baseline data from 2012/13 as detailed below:

KPI Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2012/13 Baseline numbers – complaints	3	4	6	3	4	6	8	7	1	7	5	2	55
2012/13 Baseline numbers – concerns	20	19	12	14	8	10	11	6	6	10	8	8	132

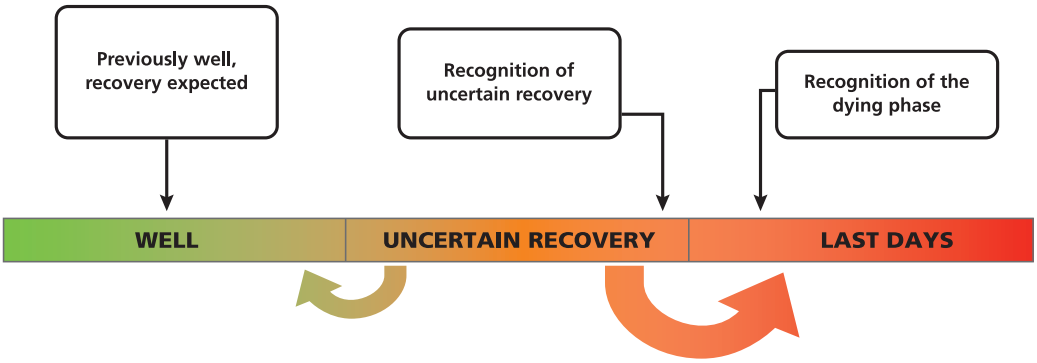
2.1.5 PRIORITY 4: End of Life Care (Amber Care Bundle) (Patient Experience)

The **AMBER care bundle©** was developed at Guy's and St. Thomas' NHS Foundation Trust through an initiative that was funded by Guy's and St. Thomas' Charity. It was developed to improve the quality of care of patients who are at risk of dying in the next one to two months but may still be receiving active treatment.

It is a simple tool which combines identification questions, four clinical interventions and systematic monitoring that can be applied in adult ward settings. It has been used in seventeen hospitals in the English NHS with a wider network which is committed to implement AMBER care bundle in their hospitals.

Evidence suggests the **AMBER** care bundle results in:

- improved decision making.
- positive impact on multi-professional team communication and working.
- increase in nurses' confidence about when to approach medical colleagues to discuss treatment plans.
- patients being treated with greater dignity and respect.
- greater clarity around preferences and plans about how these can be met.
- improved decision making.
- lower emergency readmission rates.



AMBER stands for:

- **A**ssessment
- **M**anagement
- **B**est practice
- **E**ngagement
- **R**ecovery uncertain

http://www.ambercarebundle.org/homepage.aspx

Most people would prefer to die in a place of their choosing, whether that be a hospital; their own home; a care home; Hospice or other setting. This requires people and their families to be involved in decision-making and planning for the end of life and appropriate community based support. Evidence suggests that having a documented advanced care plan in place; that includes preferred priorities for care/death and where this is communicated to members of the care team, will increase the chance of a person achieving their preferred place of death.

The Isle of Wight NHS Trust is keen to implement the **AMBER Care Bundle** to make it easier for Nurses and Consultants to have appropriate planning conversations with patients whose recovery is uncertain, thereby enhancing the patient experience and care of patients with palliative care needs and enables patients to be involved in decisions about their care and where they wish to die.

Key performance indicators for 2013/2014

Measure	Data Source	Frequency	Data collected and reported by
Implementation			
Number of agreed wards using the AMBER Care bundle – target 100%	In development	Monthly	Relevant Wards / Departments
Number of patients on the AMBER Care Bundle	In development	Monthly	Relevant Wards / Departments
Evaluation & Impact			
Audit of patients' healthcare records in January 2014 – 60% of patients audited have completed AMBER care bundle	In development	Annually	Relevant Wards / Departments

This priority has been chosen from feedback received from the recent consultation on quality goals, with End of Life Care being the most suggested theme, alongside improving communication.

2.2 Statements of Assurance from the Board

2.2.1 Review of Services

During 2012/13 the Isle of Wight NHS Trust provided and/or sub-contracted 76 NHS services.

The Isle of Wight NHS Trust has reviewed all the data available to them on the quality of care in 62 of these NHS Services.

The income generated by the NHS services reviewed in 2012/13 represents 77% per cent of the total income generated from the provision of NHS Services by the Isle of Wight NHS Trust for 2012/13.

2.2.2 Dashboards & Scorecards

Following on the work undertaken last year, in the development of the Clinical Quality Indicators dashboard; the hospital mortality dashboard and the 2 dashboards focusing on prescribing and Pharmacy, new developments are taking place to enable the collection and analysis of real time data, with the continued focus on the different aspects of quality.

Dashboards will continue to be used at the monthly Directorate Performance Reviews as part of the overall performance management process to highlight positive performance and to enable actions to be taken to address any performance issues. This will be further enhanced through the use of real time data which will be provided by the new Quality Dashboard which is in the final phase of development.

The Isle of Wight NHS Trust continues to seek innovative ways of providing the most up to date and accurate data to support the drive for continuous improvement in services provided to our patients and this will continue throughout 2013/14.

2.2.3 Patient Safety Walk Arounds

The organisation has reviewed the process for its Patient Safety Walkrounds during 2012/13 and whilst the process continues to be based on the principles of the process designed by Dr Allan Frankel, an Anaesthetist from Boston, USA, these Walkrounds have now been designated 'Board Assurance Walkrounds' and include both the Executive and Non-Executive Directors of the Trust.

The schedule of visits has been amended to encompass both weekly visits undertaken primarily by the Executive Team and Trust Chairman and monthly Walkrounds by all Trust Board members as part of the Trust's monthly board meetings. All of these visits, whilst timetabled for the year, are unannounced to the area being visited.

The Board Assurance Walkrounds offer the opportunity for the Trust Board to link directly with services delivered in all areas of the Organisation. This process provides patients; relatives and staff the opportunity to discuss issues directly with the Trust Board and also provides an opportunity for the Trust Board to seek assurance from all services. The Walkrounds are seen as pivotal in organisations who seek assurance at the point of service delivery. This also demonstrates the Trust Boards leadership commitment to quality and setting a culture to be fostered across the entire organisation.

During the course of 2012/13 a total of 35 scheduled walk rounds took place covering acute services including inpatient wards at St. Mary's Hospital, Mental Health and Learning Disabilities Services and Community Services, including District Nursing. These were attended primarily by two members of

the Executive Team and the weekly visits were also supported by a member of the senior nursing team.

Key issues identified during these Walkrounds that required further action to be taken to address them included:

- Requirement for small works to be undertaken to improve the environment.
- Systems and processes place to ensure that clinical issues were addressed in relation to infection control.
- Improvement to be made in relation to communication with patients.
- Ensuring action was taken following the receipt of a complaint.
- Small items of equipment have been purchased to improve clinical practice.
- Business cases are in development to further improve the environment on a longer term basis for two areas of the Trust.

The original process, in place from April 2012 until December 2012, did not provide the ability to centrally monitor actions arising from visits; however changes were made to the process in January 2013 whereby action plans are now collated centrally and presented back to the appropriate Clinical Directorate Management Teams for action. The Directorates are asked to provide assurance on the actions taken to the Trust Board on a monthly basis.

As the programme begins to further embed and develop, a number of out of hours visits have been included in the scheduled for 2013/2014, which also incorporates visits to non-clinical settings.

2.2.4 Participation in Clinical Audits

During 2012/2013, 34 national clinical audits and 7 national confidential enquiries covered NHS services that the Isle of Wight NHS Trust provides.

During that period the Isle of Wight NHS Trust participated in 95% national clinical audits and 88% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

During 2011/2012, 39 national clinical audits and 1 national confidential enquiries covered NHS services that the Isle of Wight NHS Trust provides.

During that period the Isle of Wight NHS Trust participated in 77% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Isle of Wight NHS Trust was eligible to participate in during 2012/13 are outlined in the table below:

The national clinical audits and national confidential enquiries that Isle of Wight NHS Trust participated in during 2012/13 are outlined in the table below:

The national clinical audits and national confidential enquiries that Isle of Wight NHS Trust participated in, and for which data collection was completed during 2012/13 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Name of Audit	Participated	% cases submitted
Women's and Children's Health		
Paediatric Pneumonia	Yes	100%
Paediatric Asthma	Yes	100%
Diabetes (Paediatric)	Yes	100%
Epilepsy 12 (Childhood Epilepsy)	Yes	100%
Fever in Children (College of Emergency Medicine)	Yes	70%
Neonatal Intensive and special care (NNAP)	Yes	All cases – ongoing
Acute Care		
Adult Community Acquired Pneumonia (British Thoracic Society)	Yes	100%
Adult Critical Care (ICNARC CMP)	Yes	All cases – ongoing
Emergency Use of Oxygen (British Thoracic Society)	Yes	8 wards involving 171 patients
Non Invasive Ventilation	Yes	100%
National Joint Registry		All cases – ongoing
Renal Colic	Yes	98%
Trauma Audit and Research Network	Yes	114%
Blood and Transplant		
Comparative Audit of Blood Transfusion – Blood Sampling and labelling	Yes	100%
Potential Donor	Yes	All cases – ongoing
Long Term Conditions		
Adult Asthma (British Thoracic Society)	Yes	95%
Bronchiectasis (British Thoracic Society)	Yes	100%
Diabetes (Adult)	Yes	28 patients
Inflammatory Bowel Disease	Yes	Ongoing – Report to be published Jun 2014
Pain Database	Yes	All cases – ongoing
Renal Registry	Yes	All cases – ongoing
Trauma		
Hip fracture database	Yes	All cases – ongoing
Cancer		
Bowel Cancer	Yes	All cases – ongoing
Head and neck Oncology (DAHNO)	Yes	All cases – ongoing
Lung Cancer	Yes	All cases – ongoing
Oesophago-gastric cancer	Yes	All cases – ongoing

Heart & Cardiovascular disease		
Cardiac Arrest Audit (ICNARC)	Yes	Ongoing – Report to be published Jun 2014
Cardiac Arrhythmia	Yes	Ongoing – Report to be published Jun 2014
Heart Failure	Yes	Ongoing – Report to be published Jun 2014
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	All cases – ongoing
Older People		
Fractured neck of femur	Yes	100%
Parkinson's Disease*	No	
Stroke National Audit Programme (SSNAP)	Yes	All cases – ongoing
National Audit of Dementia	Yes	100%
Mental Health		
Prescribing Observatory for Mental Health (2 audit topics – prescribing for people with a personality disorder; Screening for metabolic side effects of antipsychotic drugs)	Yes	45 cases in total
Psychological Therapies**	No	
Confidential Enquiries		
Asthma Deaths	Yes	100%
Child Health	Yes	1 case (100%)
Maternal Infant and Perinatal Death	Yes	All cases – ongoing
Patient Outcome and Death – Subarachnoid Haemorrhage***	No	No eligible cases identified
Patient Outcome and Death – Alcohol Related Liver Disease	Yes	100%
Patient Outcome and Death – Cardiac Arrest Procedures****	Yes	No Cases included in study
Suicide and Homicide	Yes	All cases – ongoing
Elective Surgery (National PROMs Programme)	Yes	HES Episodes not available

In relation to the following audits, these were not participated in for the reasons stated below:

*Isle of Wight Patients are managed under the care of **University Hospital Southampton NHS Foundation Trust** Neurology service and therefore our patients would be included in their audit cohort.

**The Service had taken the decision in 2011 not to participate in the National Audit of Psychological Therapies following careful consideration. The Directorate Management Team felt that the audit was poorly designed with ill defined criteria which meant that meaningful benchmarking would be impossible. Despite providing feedback to the National Team to encourage a more appropriate and clear audit methodology, the second round of

audit was not amended, and therefore the team made the decision to not participate in this audit.

***Patient Outcome and Death – Subarachnoid Haemorrhage: the Trust was unable to participate due to no eligible cases being identified during the study period.

****Patient Outcome and Death – Cardiac Arrest Procedures: the Trust were registered for this study, however the 4 cases submitted were not included by NCEPOD in the study.

The reports of 5 national clinical audits were reviewed by the provider in 2012/13 and the Isle of Wight NHS Trust intends to take the following actions to improve the quality of healthcare provided:

- Improve education of staff in relation to diabetes and the management of deteriorating patients.
- Review the Medical staffing levels and rotas to support the care of the critically ill patients.
- Review and update policies in line with audit findings and recommendations.
- Review antenatal screening programme pathway.

The reports of 15 local clinical audits were reviewed by the provider in 2012/13 and the Isle of Wight NHS Trust intends to take the following actions to improve the quality of healthcare provided:

- Improvements to be made in relation to Physiotherapy following Total Knee replacement on discharge from hospital, to include earlier assessment and follow up.
- Documentation has been updated to support improved care for women who have multiple pregnancies.
- Guidelines have been updated on the use of Clomiphene and its outcome in infertility patients.
- Management of care of the dying patient, by improving documentation and education.
- Improved handover of care to support the safe transfer of patients.

Clinical Audit Prize

The annual competition for the Clinical Audit Prize is open to all staff who undertake an audit within the Isle of Wight NHS Trust during the previous financial year. The shortlisted finalists present their audit project to an invited audience, which includes senior staff from across the organisation, an invited panel of judges are asked to judge the projects based on the structure and outcome of the audit project.

In June 2012, the fourth year of the competition, the winner was Dr Dale Duncombe who undertook an audit of Sedation and Delirium in the Intensive Care Unit, the aim of the audit was to assess the current practice within the intensive care unit regarding sedation levels and the appreciation of delirium in patients.

2.2.5 Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by the Isle of Wight NHS Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 709.

There were 29 clinical staff participating in research approved by a research ethics committee at the Trust during 2012/13. These staff participated in research covering the clinical specialties of Cardiovascular, Immunology & Inflammation, Cancer, Dementia, Diabetes, Mental Health, Stroke and Rehabilitation, Ophthalmology, Paediatrics, Reproductive Health and Childbirth, Respiratory and Pre-Hospital Care.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

2.2.6 Goals Agreed with Commissioners

A proportion of Isle of Wight NHS Trust's income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between Isle of Wight NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through Commissioning for Quality and Innovation payment framework.

A summary of CQUIN achievement, quality improvement, during 2012/13 can be reviewed in the table below:

Prison Healthcare		
Achievement of national target for HCAI	Achieve Trajectory Clostridium Difficile – local limit 1	**ACHIEVED**
NHS Safety Thermometer	Monthly surveying all appropriate patients to collect data on three outcomes (pressure ulcers, falls and urinary tract infection in patients with catheters)	**ACHIEVED**
Dementia	90% of all patients aged 75 and over admitted to prison healthcare inpatient unit will follow the dementia pathway as set out in 'FAIR' and will be screened within 72 hours of admission	**ACHIEVED**
Health improvement in long term conditions	Implementation of action plan for health improvement of 4 long term conditions	**ACHIEVED**
Patient Experience	Undertake an annual patient experience survey in M6 using survey tool developed in 2011/12	**ACHIEVED**



Acute		
Achievement of national targets	1. 80% of patients diagnosed with a stroke spend 90% of their time on a Stroke Unit (not achieved for one month)	PARTIALLY ACHIEVED
	2. 80% of TIA patients at high risk of stroke assessed and treated within 24 hours (not achieved for one month)	PARTIALLY ACHIEVED
	3. 85% of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral or suspected cancer	ACHIEVED
	4. 90% of patients receiving first definitive treatment for cancer within 62 days of a referral from an NHS Cancer Screening Service	ACHIEVED
	5. 86% of patients receiving first definitive treatment for cancer within 62 days of a Consultant decision to upgrade their priority status	ACHIEVED
	6. 96% of patients receiving first definitive treatment within one month of a cancer diagnosis	ACHIEVED
	7. 94% of patients receiving subsequent treatment for cancer within 31 days where that treatment is surgery	ACHIEVED
	8. 98% of patients wait no more than 31 days for second of subsequent cancer treatment – drug treatments	ACHIEVED
	9. 94% of patients wait no more than 31 days for second of subsequent cancer treatment – radiotherapy	N/A Not provided by IW NHS Trust
	10. 93% of patients seen within 2 weeks of an urgent GP referral for suspected cancer (not achieved for three months)	PARTIALLY ACHIEVED
	11. 93% of patients seen within 2 weeks of referral for breast symptoms (where cancer not initially suspected)(not achieved for three months)	PARTIALLY ACHIEVED
	12. % admitted within 18 weeks – 90%	ACHIEVED
	13. % Non admitted within 18 weeks – 95%	ACHIEVED
	14. % Incomplete within 18 weeks – 92%	ACHIEVED
	15. % waiting 6 weeks or more – <1%	ACHIEVED
	16. Total time spent in A&E is less than 4 hours – 95%	ACHIEVED
	17. Achieve Trajectory for MRSA 1 case	NOT ACHIEVED
	18. Achieve Trajectory Clostridium Difficile 13 cases (not achieved for two months but achieved by year end)	ACHIEVED
Healthy Life assessment	To support an improvement in the health assessment, brief advice and referral of SHIP patients accessing NHS providers in 3 public health priority areas (Smoking, Healthy eating & alcohol consumption)	NOT ACHIEVED
Essence of Care – Nursing Care Documentation	To implement and monitor the quality of revised nursing care documentation for assessing, planning and monitoring adult in-patient care	ACHIEVED

High Impact Innovations	Supporting the adoption of High Impact Innovations in: • Reviewing the use of Assistive Technology (not achieved) • Oesophageal Doppler Monitoring (ODM) (not achieved) • Child in a Chair in a Day (achieved) • Smartphone Tech & Telecare Pilot (not achieved)	NOT ACHIEVED
Dementia	90% of all patients aged 75 and over admitted to wards will follow the dementia pathway as set out in 'FAIR' and will be screened within 72 hours of admission	ACHIEVED
NHS Safety Thermometer	Collection of data on patient harm using the NHS Safety Thermometer harm measurement instrument	ACHIEVED
Paediatric assessment of children presenting in Beacon and A&E departments	Children presenting in Beacon and A&E who require an assessment by a Paediatrician should be assessed in A&E and Beacon; avoiding admission to the Children's Ward unless assessed as requiring admission	NOT ACHIEVED
Patient experience – personal needs	Composite indicator, calculated from 5 survey questions. Each describes a different element of the overarching patient experience theme "responsiveness to personal needs of patients"	NOT ACHIEVED
Reduce avoidable death, disability and chronic ill health from Venous Thromboembolism (VTE)	Number of adult inpatient admissions reported as having had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool (95%+ for three months; 90–94% for nine months)	PARTIALLY ACHIEVED

Community		
Achievement of the 3 defined national targets:	1. 80% of patients diagnosed with a stroke spend 90% of their time on a Stroke Unit (not achieved for one month)	*PARTIALLY ACHIEVED
	2. Achieve Trajectory for MRSA 1 case	*NOT ACHIEVED
	3. Achieve Trajectory Clostridium Difficile 13 cases (not achieved for two months but achieved by year end)	ACHIEVED
Patient experience – personal needs	Composite indicator, calculated from 5 survey questions. Each describes a different element of the overarching patient experience theme "responsiveness to personal needs of patients"	NOT ACHIEVED
Reduce avoidable death, disability and chronic ill health from Venous Thromboembolism (VTE)	Number of adult inpatient admissions reported as having had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool (95%+ for three months; 90–94% for nine months)	PARTIALLY ACHIEVED
Integrated Team Case Management	Move to integrated locality team working on Isle of Wight, based on a mutually agreed locality model	ACHIEVED
Older People Hospital Admissions from Home	Retrospective and prospective data analysis of admissions and readmissions	ACHIEVED
Rehabilitation Service Implementation Monitoring of New Service	Support integrated locality team working and case management into practice	ACHIEVED

Mental Health		
Living Well With Dementia	Improving care for patients with dementia, open to memory service, who reside in care homes	ACHIEVED
Mental Health Emergency Hub	Mental health advice, support and assessment through the hub	ACHIEVED
Achievement of the 3 defined national targets	1. % admitted within 18 weeks – 90%	N/A
	2. % Non admitted within 18 weeks – 95%	ACHIEVED
	3. % Incomplete within 18 weeks – 92%	ACHIEVED
Development of Integrated Re-enablement Team (Excl Dementia services)	Move to recovery focussed model (addressing high readmissions and delayed discharges)	ACHIEVED

Ambulance		
Achievement of national targets	75% of cat A8 calls are responded to within 8 minutes	ACHIEVED
Patient experience	Survey to determine the different elements of patient experience of the 999 (See, treat & convey) service	ACHIEVED
Data collection	Improvement of data collection and sharing, to understand and develop appropriate patient pathways thus enabling the facilitation of integrated commissioning of emergency care	PARTIALLY ACHIEVED
Patient awareness and Reduction of conveyance	Improving patient satisfaction through raising public awareness of managing patient expectation of the ambulance service. Patient survey to be conducted. Reduction of conveyance, through the increase use of Hear and Treat and See and Treat	PARTIALLY ACHIEVED

Details of the agreed goals for 2013/14 are available from the Quality Team; Isle of Wight NHS Trust, St. Mary's Hospital, Parkhurst Road, Newport, Isle of Wight, PO30 5TG or via email – quality@iow.nhs.uk.

2.2.7 Francis Review of Mid Staffordshire – findings

Following the above review, published early 2013, the Isle of Wight NHS Trust has set up a designated team to review the 290 recommendations in the published report and advise on actions required. This work will form an important key focus for 2013/14.

There is also an agreed 2013/14 Commissioning for Quality and Innovation payment scheme, agreed with the Commissioners, relating to this review that links to the work being undertaken by the Trust. This requires the organisation to undertake a review of both the Francis Report and the Compassion in Practice Strategy to be undertaken to analyse and understand the implications of both reports and the recommendations and learning to be taken forward by Isle of Wight NHS Trust. Along with this the Trust needs to develop a strategy for implementing and putting into practice, an action plan for delivering the recommendations and learning.

2.2.8 What Others Say about the Provider

Statements from the CQC

The Isle of Wight NHS Trust is required to register with the Care Quality Commission (CQC) and its current registration status is fully registered with no compliance conditions attached.

The Care Quality Commission has not taken enforcement action against Isle of Wight NHS Trust during 2012/13.

Isle of Wight NHS Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2012/13:

1. St. Mary's Hospital – 10 and 11 January 2013 Routine Inspection (unannounced)

The Care Quality Commission (CQC) assessed the regulated activities, diagnostic and screening procedures, surgical procedures and the treatment of disease, disorder or injury. They inspected two surgical wards, the Discharge Lounge and the Rehabilitation Unit. The inspection was carried out over two days and the Inspectors from the CQC spoke with 21 patients and relatives, 14 staff including Nurses and Physiotherapists. Patients they spoke with were happy with the care they received and there were areas of good practice identified, such as monitoring and recording of surgical site infections and referral to specialist advisors such as pain specialist. Consent to treatment was well documented and staffing levels were well maintained, with no significant vacancies in any of the areas visited. Patients stated that staff were 'busy' but this did not have a significant impact on the care they received. They said that staff responded well to the call bells with occasional waiting times but nothing that they would complain about.

Summary of Findings

Standards of treating people with respect and involving them in their care	✓	met this standard
Standards of providing care, treatment & support which meets people's needs	✓	met this standard
Standards of caring for people safely & protecting them from harm	✓	met this standard
Standards of staffing	✓	met this standard
Standards of management	✓	met this standard

Isle of Wight NHS Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

The CQC inspection of St. Mary's in January 2013 included no specific recommendations and therefore no action plan was required by the CQC. The Isle of Wight NHS Trust has reviewed the small number of suggestions within the published report and a local improvement plan is in place, which is ongoing.

2. Prison Healthcare – HMP Isle of Wight – 23 May 2012 Routine Inspection

This inspection concerned the physical and mental health services at The Isle of Wight Prison. The inspection was conducted jointly with staff from Her Majesty's Inspectorate of Prisons (HMIP). Prisoners were spoken to individually, in small groups whilst waiting at the health centres and in larger formal groups, covering the full range of prison life including healthcare. There was considerable praise for the mental health services. Prisoners commented that they had received swift treatment when they had begun to self harm. There were a small number of adverse comments about the time taken to access mental health services. There were mixed views on the provision of physical health. A number of prisoners complained that the waiting time to see a doctor was too long and some said that the appointments' system was unreliable. Prisoners were sometimes not taken to appointments, where an escort was required, or sometimes they did not receive appointment slips. Other prisoners had nothing but praise for the healthcare on offer with comments like "the best I have ever seen" and "they have got it right."

The CQC report dated June 2012 advised that HMP Isle of Wight was meeting all the essential standards of quality and safety inspected. It highlighted that there had been year on year improvement since 2006. Areas of exemplary practice were noted and which might be used as good practice in national guidance.

Summary of Findings

Standards of treating people with respect and involving them in their care	✓	met this standard
Standards of providing care, treatment & support which meets people's needs	✓	met this standard
Standards of caring for people safely & protecting them from harm	✓	met this standard
Standards of staffing	✓	met this standard
Standards of Quality & Suitability of management	✓	met this standard

Isle of Wight NHS Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

The CQC inspection of Prison Healthcare in May 2012 included no specific recommendations and therefore no action plan was required by the CQC.

3. Shackleton House – 5 December 2012 Mental Health Act 1983 monitoring visit (unannounced)

By law, the Care Quality Commission (CQC) is required to monitor the use of the Mental Health Act 1983 (MHA) to provide a safeguard for individual patients whose rights are restricted under the Act. They look across the whole patient pathway experience from admission to discharge – whether patients have their treatment in the community under a supervised treatment order or are detained in hospital.

Shackleton House is a 9 bed Older Persons Dementia Assessment Unit and this inspection looked at the following elements of the monitoring Framework for the Mental Health Act 1983:

Domain 2: Detention in Hospital
Purpose, respect, participation and least restriction
Control and security
Consent to treatment
General Healthcare

The CQC report highlighted very good nursing care which was given with a high level of respect and obvious concern for patients' dignity. Statutory Mental Health Act documentation was scrutinised and found largely to be in order. Care plans and risk assessments were also examined and found to be comprehensive and patient-centred. Care given was in accordance with the care plans and in line with the Trust's policy and guidelines and that the unit provides a valuable outreach service which has proved to be very effective in preventing admissions.

Adverse findings were reported in relation to the environment, in that the physical environment does not minimise the undesirable effects of patients with severe dementia, nor does it promote their recovery and wellbeing and staffing.

The CQC report outlined relevant recommendations that the Isle of Wight NHS Trust was asked to respond to, see table below. Isle of Wight NHS Trust intends to take the following action to address the conclusions or requirements reported by the CQC in relation to Shackleton House:



Recommendations	Actions
The Trust will ensure that the necessary medical input is provided in a timely manner when urgently required at Shackleton	All future Medical Trainees will be assessed against their ability to provide cover to sites not at St. Mary's.
	Out of hours cover continues to be provided by Senior House Officers (SHO) and Consultant Psychiatrists on call.
	If a junior grade doctor is unable to attend a unit, then the medical response will be provided by Consultant Psychiatrists. The current intake of SHOs who cover units all drive and would be able to attend urgently if required.
	Shackleton will be moving to a ward on the St. Mary's site by March 2013, where upon these potential difficulties will be minimised. In the mean time any member of staff who is required to attend the Shackleton site will optimise the Trust taxi contract.
The Trust will address the long overdue improvements to the environment in which these highly vulnerable patients are treated	An action plan has been developed to ensure that the building remains in a reasonable and adequate state for patients until the move will be completed. This is expected to complete in March 2013.
	Shackleton will be moving to a ward environment on the St. Mary's site by March 2013, whereupon these the environmental problems that the staff and patients have faced will cease.
Assessments of capacity will be undertaken and recorded in line with the requirements of the Code of Practice	In the Inpatient care pathway notes there is a sheet on which weekly ward reviews will be recorded. Contained within this is a section that requires a note to be made of the discussion regarding a patients capacity.
	These forms will be used routinely in all ward environments with immediate effect.
	Monthly audit will be undertaken by registered Nurses, the results will be shared at Acute Leads and action plans will be shared and monitored by the Acute Leads. The Quality Risk & Patient Safety Group will receive any exceptions and make recommendations appropriately.
	Implementation of the new Patient Record Information System (PaRIS) electronic record system will support more effective monitoring of compliance.

Isle of Wight NHS Trust has made the following progress by 31st March 2013 in taking such action:

- Trainees have their transport needs assessed before being allocated to offsite units; the current unit is moving on to St. Mary's site in early June 2013.
- Work is almost complete to new unit with handover expected 24th May and patients moving in from 3rd June 2013.
- A system of audit has been implemented to provide assurance that capacity is assessed routinely.

2.2.9 Data Quality

i) Statement on relevance of Data Quality and actions to improve data quality

High quality information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. It plays a key part in clinical governance, service planning, performance and business management that all help to demonstrate the quality of the services we provide. Therefore the Trust views Data Quality as an essential element of delivering high quality health care service.

Whilst some elements of our data quality are extremely high work to monitor and improve data quality is ongoing in order to drive continual improvement.

The Isle of Wight NHS Trust will be taking the following actions to improve data quality:

Continuation of the Counting and Coding Project – this project has been set up to address any areas where data capture could be improved, as well as providing assurance that activity data accurately reflects care provided. The benefits of complete and consistent data delivered via this project include:

- Enablement of patients and commissioners to compare services, based on quality.
- Enablement of effective benchmarking analysis.
- Provision of clear understanding of the needs of service users.
- Supporting the consistent application of the PbR (payment by results) tariff and a consistent basis for savings and investment plans.
- Supporting the delivery of better care through accurate, timely funding.

The Trust is subject to a series of audits that cover elements of data quality (both internal and external undertaken to review various business processes – Payments by Results, Clinical Coding, Information Governance) and these report to Board via the Audit Committee and Information Governance Steering Group.

In addition the Trust has an approved Data Quality Policy to support a culture and ethos of good data quality throughout the organisation and achieved level 2 compliance in all the data quality requirements within the Information Governance Toolkit.

In order to continue to improve the quality of data reported, work is underway to develop an Information Assurance Framework that will support the Data Quality Policy and will link with the work currently underway on the development of a real time reporting quality dashboard. To provide the Trust Board with assurance regarding the quality of information presented to them, the Trust's Performance Information Department have undertaken an assessment of the data relating to all metrics in the Trust Board Performance Report. A report of the findings from this assessment will be presented to the Trust Board on 26 June 2013.

ii) NHS Number and General Medical Practice Code Validity

The Isle of Wight NHS Trust submitted records during 2012/13 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

Which included the patient's valid NHS number was:

98.3% for admitted patient care;

99.3% for out-patient care; and

97.9% for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:

100% for admitted patient care;

100% for out-patient care; and

100% for accident and emergency care.

iii) Information Governance Toolkit Attainment Levels

The Isle of Wight NHS Trust's Information Governance Assessment Report score overall score for 2012/13 was 82% and was graded Green.

iv) Clinical Coding Error Rate

The Isle of Wight NHS Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnoses Incorrect [3.2%]
- Secondary Diagnoses Incorrect [9.9%]
- Primary Procedures Incorrect [8.3%]
- Secondary Procedures Incorrect [11.6%]



PART 3

3.1 Review of Quality Performance

3.1.1 Improving Mortality Rates

Reducing Hospital Standardised Mortality Ratio	Achieved
Reducing Standard Hospital Mortality Index	Achieved

During the past 12 months Isle of Wight NHS Trust has continued to improve its mortality position for which it had been identified as a national outlier in 2011. As anticipated it reduced its mortality rate in 2012/2013, with the latest figures being an HSMR of 101 for the period April 2012 to March 2013 (rebased at 107, see figure 1) and SHMI of 1.0609 for the period October 2011 to September 2012 (figure 2).

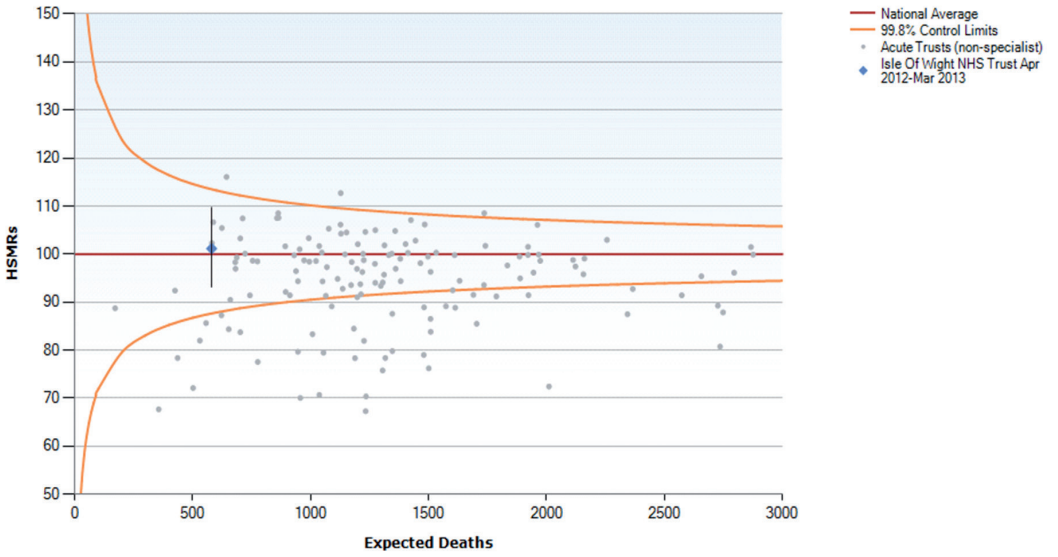


Figure 1: HSMR Performance

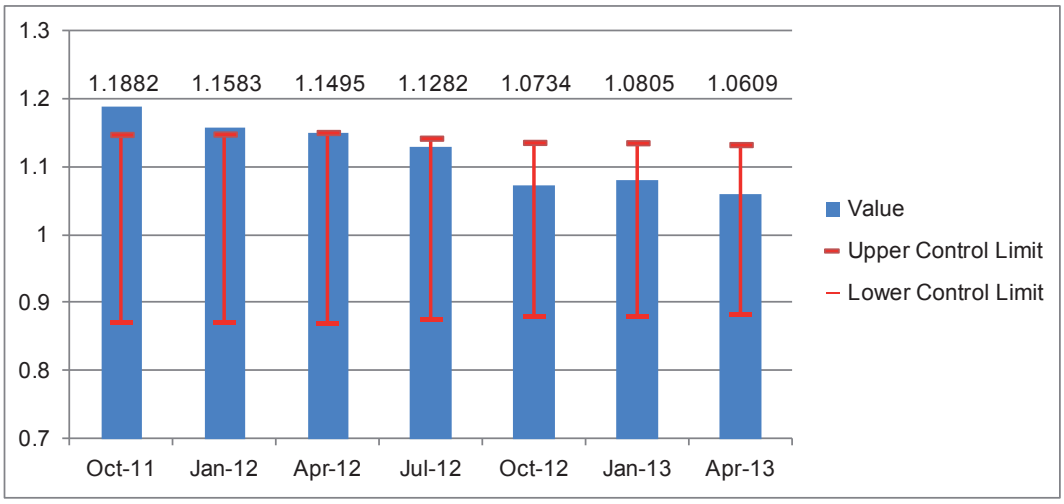


Figure 2: Isle of Wight NHS Trust SHMI Value against the expected range

The cross organisational Mortality Action Plan has driven through improvements in the organisations quality of clinical coding and specific areas of clinical practice. Directorates have also during the year worked closely with the Dr Foster tool to highlight areas where potential improvements in patient care could be made. Where a raised number of expected deaths are evident; reviews and audits are undertaken to ensure any areas of patient safety are addressed. A review of renal failure associated deaths was undertaken in November 2012 but showed no clear common themes in relation to clinical care but did revealed where improvements in coding should be made.

In June 2012 the organisation commenced the electronic prescribing system, which has reduced prescribing errors and missed and late doses. Since October 2012 all community deaths are now coded from full notes meaning that the organisation has improved the richness of clinical coding for this group of patients. During winter 2012 the organisation also increased to daily consultant ward rounds and dedicated physicians to care for the increased number of frail elderly patients that the winter brings. Its successful Critical Care Outreach team has also made significant inroads to reducing the number of cardiac arrests in the hospital by improved monitoring of deteriorating and at risk patients and as of July 2013 will move to a 24/7 service.

Mortality monitoring arrangements in 2012/13 have also been improved with quarterly reporting on the organisations mortality position to the Quality & Clinical Performance Committee, regular updates to Trust Board along with weekly 'Flash Reporting' to the Executive Team and Non Executive Directors. This Flash Report provides an overview of the number of deaths within the hospital on a weekly basis and indicates if there is an increase from the previous week or above an expected tolerance number. Where the tolerance is exceeded, an analysis is conducted by the Quality Team and Executive Medical Director. A review of all deaths in hospital was undertaken for January and February which saw a slight increase mostly due to infection related death in the elderly and highlighted no correlating themes.

3.1.2 Prevention and Management of Pressure Ulcers

Reduction in % patients admitted who develop a pressure ulcer grade 2 and above	**Not Achieved**
Reduction in prevalence of pressure ulcers grade 2 and above, in the hospital setting	**Achieved**
Reduction in number of patients with grade 3 and 4 pressure ulcers by 25% on 2011/12 baseline	**Not Achieved**

The last year has seen a large number of initiatives to support patients to avoid the development of pressure ulceration. These have included ongoing ward review on a weekly basis of pressure ulcer documentation by the Nutrition and Tissue Viability Service to support good care planning.

Educational sessions have been undertaken in both the hospital and community settings to support relevant staff in the delivery of pressure ulcer prevention and management. These educational sessions have not just been offered to Nurses but also to Allied Health Professionals such as Physiotherapists and Occupational Therapists, who play a key role in the mobilisation and rehabilitation of patients in all settings.

The implementation of the generic assessment documentation and care planning documentation has supported the standardisation of assessment tools and the tissue viability care plans underpin good quality clinical care.

Performance against the three 2012/2013 key measures are outlined below:

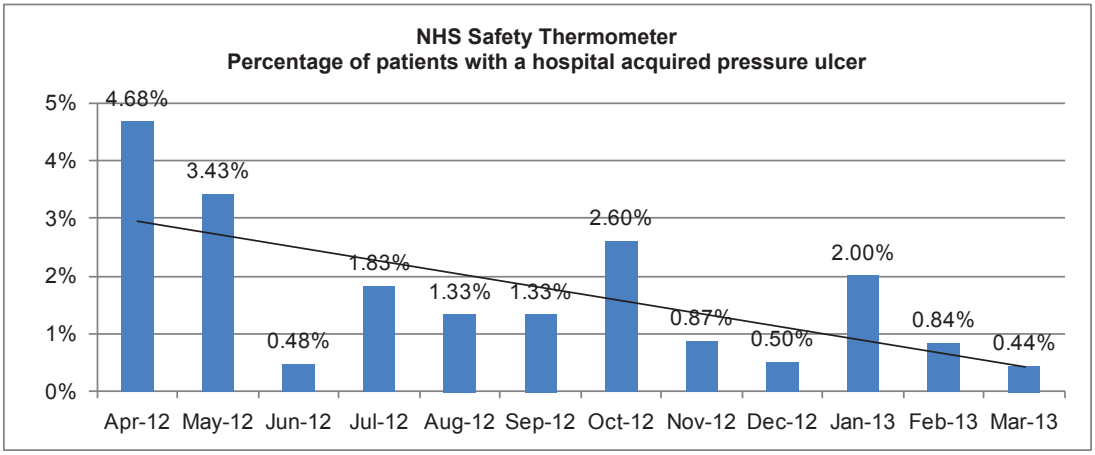


Figure 1: Prevalence of patients having pressure ulcers across 2012/2013.

Overall, the prevalence of patients having pressure ulcers across the year has fallen (figure 1). This is the number of patients who at any one point in time in the hospital setting have acquired a pressure ulcer during their stay. The prevalence of pressure ulcers is one of a number of indicators taken from the NHS Safety Thermometer; a tool that is used to describe how safe the care is, provided in hospital and community settings.

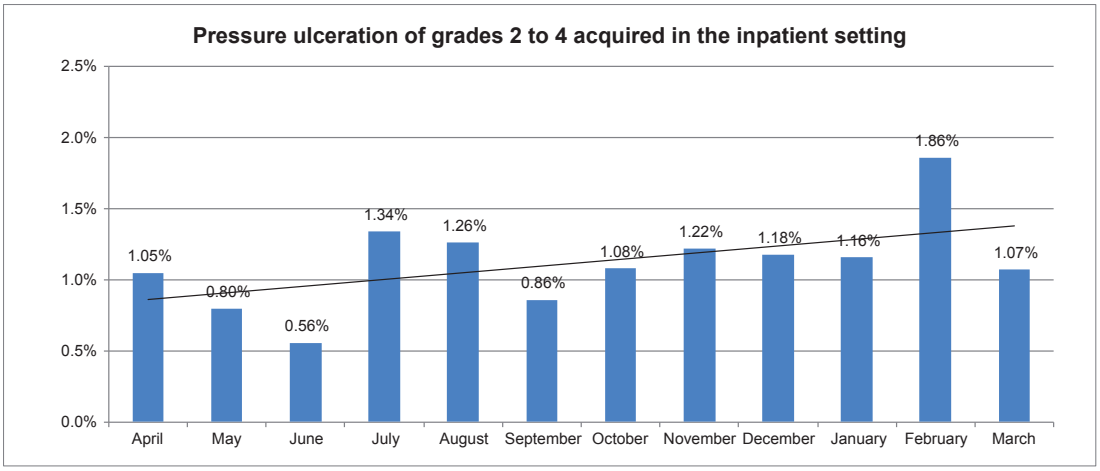


Figure 2: Incidence of pressure ulcers grade 2 to 4 in hospital setting.

Incidence of pressure ulcers of grades 2 to 4 (figure 2) reported as a percentage of patients has fluctuated over the past year. This measurement is derived from the number of patients discharged against those acquiring pressure ulcers whilst in the hospital setting. As this measure is relative to the number of beds in the hospital setting, part of the change in this measure may be accounted for by the reconfiguration of the beds in hospital that has occurred over the last year.

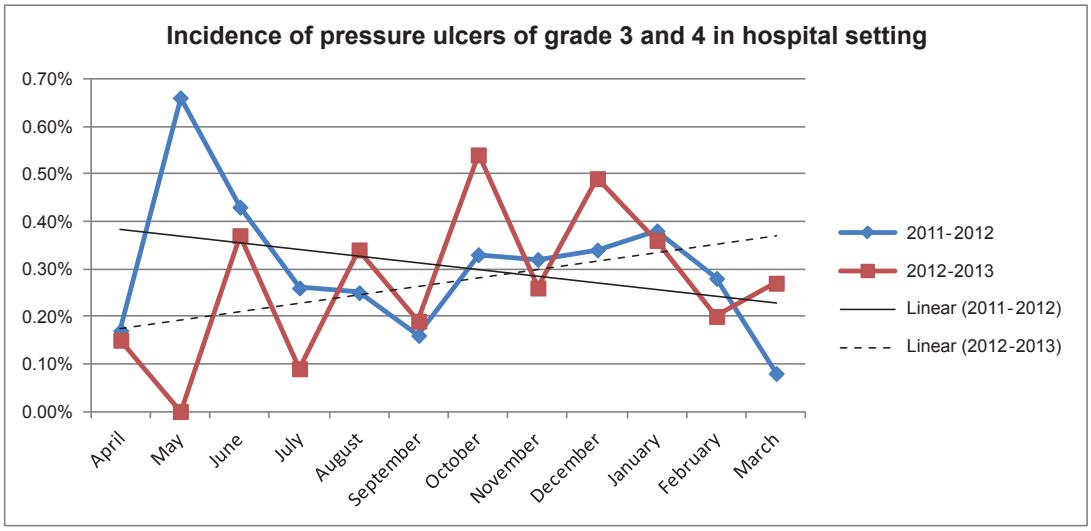


Figure 3: Incidence of pressure ulcers of grade 3 and 4 in hospital setting.

The Isle of Wight NHS Trust is committed to reducing incidence of the most serious types of pressure ulcers (grade 3 or 4) to below the levels experienced in 2012/13. The target of 25% reduction was not achieved during the last twelve months, although there was a decrease in some months. Therefore, reducing pressure ulcers will remain a key quality priority for 2013/14 with new key performance indicators developed to support this work; more detail can be found in section 1.

3.1.3 Improving Access to Level 1 and Level 2 Child and Adolescent Mental Health Services (CAMHS)

100% of patients seen within 18 weeks from referral to treatment – achieved, except November 2012 (2 patients outside 18 weeks)	**Achieved**

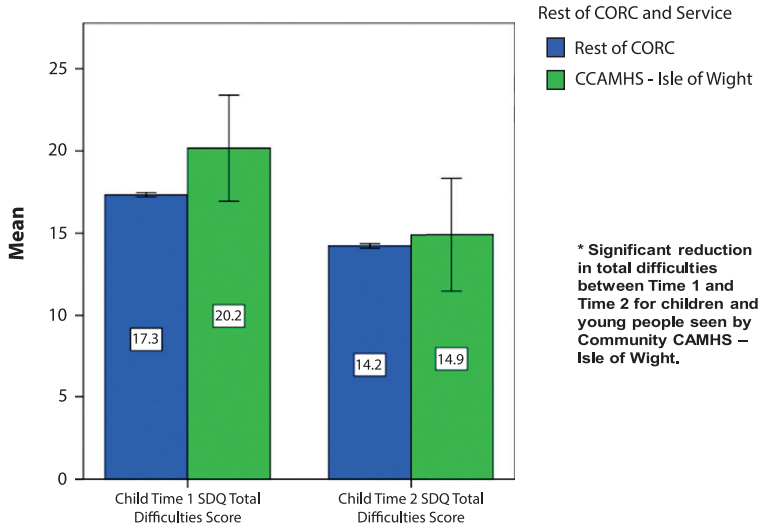
The Community CAMHS Clinic at Pyle Street was given a facelift in April 2012, with the whole department upgraded in order to make the building safe and fit for purpose. This made for a more child friendly environment, in turn reducing anxiety and stigma about mental health. The redesign of the reception area and co-ordinated internal colour scheme now promotes a calm atmosphere and easier access for children and wheelchair users. This project has significantly improved the environment and confidential space for young people experiencing emotional difficulties and has provided dedicated rooms for family therapy, relaxation and sensory awareness and for creative therapeutic sessions.

The service has introduced the use of various quality data tools in order to monitor progress during treatment. At the initial appointment all new patients and their parents complete a Strengths and Difficulties Questionnaire. This is repeated after four months, or at discharge (if sooner), along with a Child Global Assessment Scale and HONOSCA (Outcome Measure) being completed by the clinician. All of this data is recorded and evaluated by the CAMHS Outcome Research Consortium in August when our data is measured against other CAMHS teams nationally. As August 2012 was the first year of contributing our data, there was no baseline to measure against, however figures showed a positive outcome from the child's perspective (see chart below):

Children and Young people's report of total difficulties

Based on: the subtotal of questions on the SDQ completed at first appointment and then 4-8 months after first contact
A Total Difficulties Score is calculated between 0 and 40 and scores above 20 are considered to be clinically significant.

Please note this graph displays the mean total difficulties scores and 95% confidence intervals of the mean.



*** Significant reduction in total difficulties between Time 1 and Time 2 for children and young people seen by Community CAMHS – Isle of Wight.**

CORC CAMHS Outcomes Research Consortium

The service is continuing to improve data collection and in August 2013, will be submitting data for the second year, so this will enable service development to be targeted appropriately based on evidence.

During the past year, Community CAMHS Practitioners have been involved in delivering training and practice development sessions with our Education and Health Colleagues in the Solihull Approach; bringing together theories from health, psychology and psychotherapy to develop a model of working with young people and their families. This training has been delivered to over sixty professionals working with, babies and children up to five years and professionals involved with school aged children. The service has received requests for specific training from various agencies regarding issues of concern and will continue to develop training in line with the emotional health and wellbeing agenda.

Community CAMHS have set up regular consultation groups within Children's Centres and Schools to provide emotional health and wellbeing support to professionals working in statutory and voluntary agencies across the Island. The three primary Mental Health Practitioners have developed a patch model across the localities identified by the Common Assessment Framework (CAF) and have developed a good local network to provide support and advice to children and families as well as clinical brief interventions and family therapy if appropriate.

There are regular meetings with paediatric colleagues and joint clinics for complex cases have been set up with our consultant psychiatrists as well as continuing the bi monthly meetings developed to incorporate closer working practices and develop shared pathways for patient care.

Performance against the key measures set out in the Isle of Wight NHS Trust's 2012/2013 Quality Account, was excellent as outlined in the table below:

KPI Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
100% of patients seen within 18 weeks from referral to treatment	100%	100%	100%	100%	*No appt	100%	100%	83%	100%	100%	100%	100%

*Relates to no 1st seen appointments during August 2012

All of the work undertaken over the last twelve months has enabled achievement of the above key priority, in all but one month, November 2012. This target will, therefore, not be included in the 2013/14 key quality priorities, although the service will continue to deliver against key targets, which will be monitored via the relevant Directorate Board or the Directorate's Quality, Risk and Patient Safety Committee, as appropriate.

3.1.4 Improving Nutrition and Meal Times

Increase compliance with Malnutrition Universal Screening Tool	**Achieved**
Weight of patients on admission & discharge (indicator changed mid-year – see text below)	**Not Achieved**

The Isle of Wight NHS Trust needed to understand the different factors that affect the nutritional needs of vulnerable older patients. A project commenced in 2012 to examine this on Newchurch Ward, an acute medical ward usually caring for many frail and acutely ill older people – Newchurch Ward transferred to Appley Ward part way through the year. This pilot was part of a project instigated by the NHS Institute for Innovation and Improvement.

The primary drivers for the work included national concerns from organisations such as Age Concern and the Care Quality Commission (CQC), regarding malnourishment in the NHS, as well as a desire to achieve compliance with assessment tools and high quality care for patients.

The Trust continues to focus on safety and there was recognition that nutrition could be a contributory factor to patients falling or failing to heal properly.

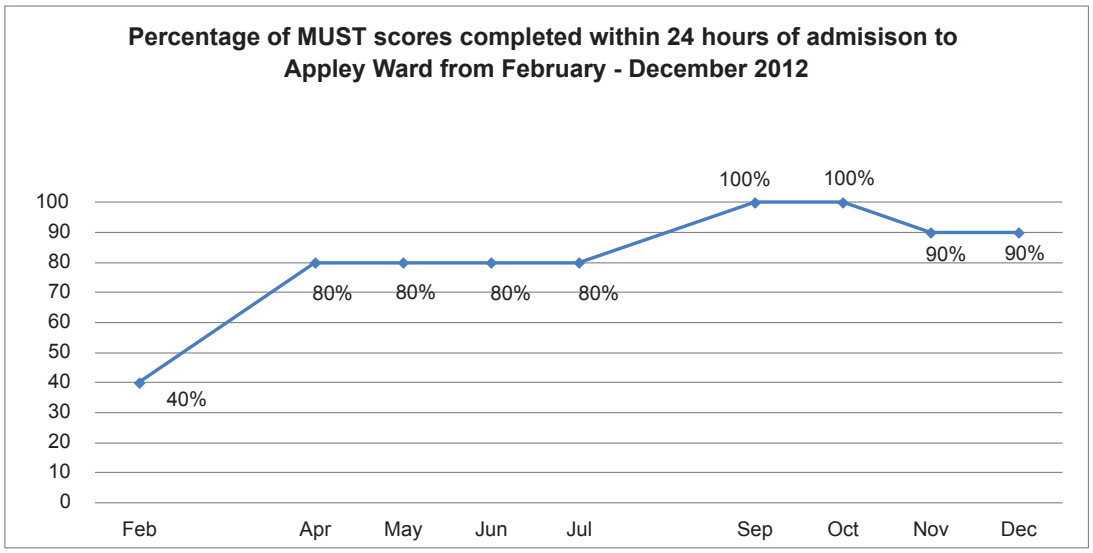
The Safe and Productive Care of Older People improvement project used three Key performance indicators:

1. The MUST (Malnutrition Universal Screening Tool) tool was being used to measure the nutritional status of all patients on admission and used accurately;

2. Measurement of the weight and BMI (Body Mass Index) of patients on admission and discharge, to check for weight loss;

3. Complaints or incidents relating to food and drink on the ward; and the eating and drinking experience of patients, as evidenced by surveys and photographs.

Initial PDSA (Plan Do Study Act) method showed that MUST scores were not always accurately recorded and were sometimes not completed within the required timescale, as can be seen from the audit results below:



KPIs 1 and 2

The graph above highlights that work carried out by the Matron and Ward Sister to improve MUST screening increased compliance from 40% to between 90 and 100%. This is an area that is important and will continue to need supervision by the Ward Sister. Part way through the project, it became clear that the BMI (Body Mass Index) of patients was a more accurate measure and this replaced the MUST scores as a measure in January 2013. The Matron reviewed what happened to patients with a sub optimal BMI. Sampling of this has shown that patients with BMI below 25 are being given supplements or referred to the dietician as appropriate. MUST scores are now being undertaken in the Medical Assessment Unit.

Weighing all patients on both admission and discharge was found to be extremely time-consuming, with the majority of patients needing to be weighed sitting or lying down. Therefore the Ward Sister commenced with weighing a sample of 25 patients per month until this was replaced with the focused review of BMI scores.

KPI 3

A survey method was used to record patient's feelings about the food and drink on the ward. Findings from this survey highlighted that menus were confusing for patients and not appetising in terms of the description of food and vegetarian options were unclear. Menus have now been changed and interviews with patients on the wards show that patients are finding the new menus much more user friendly. However more work is planned to make the menus pictorial to assist with choice for certain patients and a clearer impression of what the food will look like.

Three survey questions were added to the monthly Getting it Right Survey and the annual patient survey. These are focusing on the food and drink experience of patients and whether they received assistance to eat their meal if required. The results from this are sent to the Catering Manager and each ward receives the results as part of the Getting it Right Survey results.

Photographs taken to examine the process at lunch time demonstrated both good practice and practice that could be improved. This will now be used as an opportunity for the Ward Sister on the ward to discuss this with staff and make changes as required.

Improving nutrition and the patient experience in relation to mealtimes will remain in focus for the Trust in 2013/2014, although not specifically a priority within the 2013 Quality Account and performance will be monitored via the nutrition group.

3.1.5 Improving the Experience of Children and Young People Presenting in Psychiatric and Emotional Crisis

No children 16 or under admitted to an adult mental health ward	**Achieved**

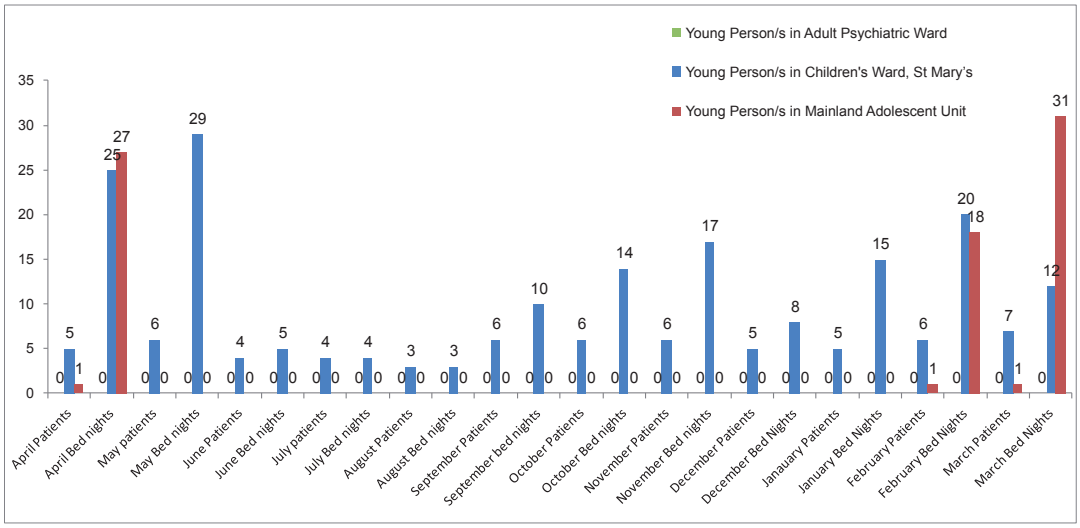
Performance against the Quality Account target measures for 2012/13 is outlined in the table below:

KPI Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
No children aged 16 or under will be admitted to an adult mental health ward	0	0	0	0	0	0	0	0	0	0	0	0
Number of children admitted to other places (incl. Mainland Specialist Mental Health Units/Children's Ward)*	6	6	4	4	3	6	6	6	5	5	7	8

*Any young person aged 16–18 if placed in an Adult mental health ward is subject to scrutiny and a report submitted to the strategic health authority.

The Inreach/Outreach Service that was set up in January 2010 has continued to provide an intensive and case specific service to young people who are either at risk of becoming an inpatient in a mainland adolescent hospital or have been admitted to the Children's Ward due to concerns about their mental health and emotional wellbeing. Last year the number of young people admitted to the children's ward was in excess of 60 and they stayed over 150 nights. There were 3 long term admissions to mainland facilities that accounted for over 450 nights. During the reporting year there were:

- 0 admissions to Adult Mental Health Ward for children under 16 (100% compliance).
- 1 overnight in July 2012 for a young person aged 17.
- 63 young people admitted to children's ward and stayed 157 nights.
- 3 young people admitted to mainland facility for 79 nights.



This is a positive endorsement of the work that has been undertaken in developing the relationship with the Children's Ward to enable children with serious emotional disorders to remain on the Island to undergo intensive community treatment and prevent the disruption caused by mainland admissions. It will however be important to track this over the next five years to ensure that this change can be sustained and this will be monitored via the Directorate's Quality meetings.

3.1.6 Learning Disabilities and Dementia

100% relevant in-patients received support from Liaison Nurse / Community Learning Disability Nurses	**Not Achieved**
Increase in proportion of "This is Me" documents completed	**Partially Achieved (2 of 4 quarters)**
90% patients aged 75+ admitted follow dementia pathway	**Achieved**
90% patient aged 75+ screened as at risk of dementia require a risk assessment using agreed tool	**Achieved**
90% patient aged 75+ screened positively for dementia; had risk assessment and referred for specialist treatment	**Achieved**

A. Improving the experience of people with a learning disability using St. Mary's Hospital

Throughout 2012/13 the Learning Disability Liaison Nurse has been in direct contact with 84 patients attending St. Mary's Hospital for single or multiple outpatient appointments, inpatient stays or Day Surgery admissions.

The main key performance indicator relating the this Quality Account priority was 100% of all in-patients with a learning disability who require adjustments in their care will receive support from the Liaison Nurse or CLDN. Performance against this target for the year can be seen in the table below:

KPI Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4
All in-patients with a learning disability who require adjustments in their care will receive support from the Liaison Nurse or CLDN	94%	93%	97%	100%

The results above clearly evidence an improvement throughout the year to enable the achievement of the 100% target by the end of quarter 4. The increase awareness of the role of the Learning Disability Liaison Nurse has contributed to the improvement in performance.

Examples of good practice are evident throughout most areas of the hospital in a number of situations where multi-professional working has eliminated the need for repeated admissions or appointments for some patients. This has worked particularly well in the Day Surgery Unit when Ophthalmologists, Ear Nose and Throat Consultants and Podiatry have all worked together whilst the patient is under anaesthetic for dental examination. Reasonable adjustments are continuously being made within this department from the initial pre-assessment visit to the flexibility of the team with attendance times and timely discharge facilitation.

The Breast Care Unit frequently demonstrates good practice and reasonable adjustments when patients with a learning disability attend for a mammogram. The staff team are very flexible and will adjust appointment times in order to reduce stress and anxieties for the patient. These adjustments have been initiated by the Learning Disability Liaison Nurse and the individual staff teams, being further developed by the identification of a learning disability champion on each ward and department. This will ease the introduction and implementation of the Learning Disability Inpatient Protocol.

The Community Learning Disability Team become involved with individual patients as appropriate on the wards, working in an inter-professional capacity alongside their peers. By utilising their specialities the patient experience can be further enhanced allowing a faster safer discharge back to community placements.

Although there have been areas of particular success over the last twelve months, there has been a general enhanced awareness of the needs and challenges for our patients with a learning disability throughout the acute wards and departments.

Although this priority will not be carried forward into the 2013/14 list of quality priorities; there will be ongoing monitoring and evidence gathering via staff satisfaction questionnaires.

The second key performance indicator relating to this quality priority was the survey of the continued use of psychotropic and anti-epileptic medication for patients with a learning disability coming into hospital. This survey was undertaken by the Consultant Psychiatrist and the audit shows that we have a low incidence of psychotropic prescribing.

This will continue to be monitored when patients are admitted to St. Mary's Hospital by the Learning Disability Liaison Nurse who will discuss and liaise with the Consultant Psychiatrist and advise the ward staff if reductions and dose adjustments are necessary.

B. Enhancing Care Provision to Patients with Cognitive Impairment / Sensory Impairment / Communication Difficulties

Although the "This is Me" document is produced by the Alzheimer's Society for those with a cognitive impairment, it can be used to support the care of any individual who for any reason e.g. visual/ hearing impairment, speech/language difficulties maybe following a stroke, who may have difficulty communicating.

The Memory Service Healthcare Assistant had a role in distributing this document to individual patients and encouraging its allocation and use by staff on the wards at St. Mary's.

The main objectives of this Quality Account priority included the following:

- To promote a culture of person centred treatment and care.
- To raise staff awareness and understanding of the special needs/ requirements of an individual who may have difficulty expressing these.
- To raise awareness of the need for interactions which are not task centred.
- To offer support to patients by engaging with them in the most appropriate and effective way.
- To work with staff to improve awareness of the need to provide individualised care.
- To improve the quality and consistency of communication to patients.
- To encourage ward staff to engage with the patient and any carers to obtain information that will impact positively on the patients experience and care.

The target measure associated with this priority was to increase the amount of "This is Me" documents given out to patients and also measure the quality of the information reported and recorded within the document.

Performance again the first target is outlined in the table below:

KPI Description	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Increase in the proportion of people with a cognitive / sensory/ or communication impairment who have the "This is Me" document completed and available at the end of their beds	33	92	32	68

The Memory service was able to account for documents distributed by the Memory Service Healthcare Assistant and was unable to obtain accurate records of the document being distributed by ward based staff.

The reduction in numbers given out in Quarters 1 and 3 can be explained by periods of leave taken during this time.

Prior to implementation of this initiative, there were none of these documents being distributed to patients, so there has definitely been an increase, although this has not been as successful as initially hoped. This initiative will continue for the benefit our patients. The Dementia Champions Group; led by Memory Service Staff promotes awareness of the needs of vulnerable patients whilst in the St. Mary's Hospital setting and it is reported that ward staff attending this group have started to distribute and use the document, so it is hoped numbers will increase further.

With regard to the quality of the information obtained and recorded there has been no improvement as this remains variable and dependent on the individuals completing the form. Work will continue through the Dementia Champions Group in order to improve the quality of recording. For information within the "This is Me" document to be accurate and informative it is always preferable for staff to support any carers in providing and recording the information.

This priority will not be carried forward to the 2013 Quality Account; however performance and achievement of relative targets will be monitored via the Mental Health Quality meetings.

C. Raising Awareness and Improving the Quality of Care for People with Dementia

Dementia is a significant challenge for the NHS with an estimated 25% of acute beds occupied by people with dementia, leading to increased length of stay due to delays in leaving hospital. The Department of Health and Commissioners have been keen to support improved dementia detection and diagnosis through the use of the National dementia CQUIN scheme during 2012/13 and the provider has used this opportunity to focus attention of this important group of patients. To re-enforce the importance of this initiative it was also made a Quality Account priority for 2012/13.

The scheme includes all patients aged 75 and over, whom are admitted with a length of stay longer than 72 hours (excluding those with known dementia or clinical unfit for assessment), and requires that over 90% of these patients are asked the Dementia Screening Questions. Subject to the result of this screening process, the provider is then required to undertake an Abbreviated Mental Test score (AMT) on more than 90% of this cohort. Finally if the patient scores 8 or less on the AMT, then at least 90% of these should be referred to the Memory service (or other appropriate service).

The Isle of Wight NHS Trust needed to achieve the following as part of the FAIR (**F**ind, **A**ssess and **I**nvestigate, **R**efer) dementia process:

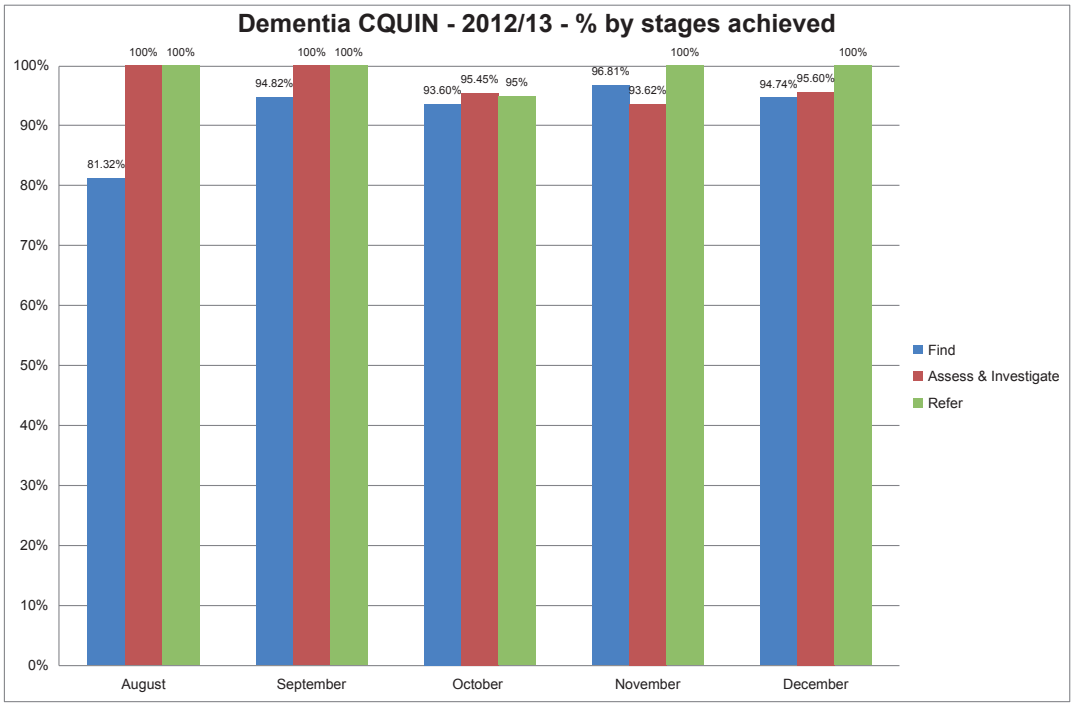
- Find – 90% or greater of eligible patients screened (75 and over staying greater than 72 hours) asked the dementia screening question.
- Assess and Investigate – 90% or greater for those patients identified as failing the dementia screening question as above, assessed using the AMT.
- Refer – 90% or greater of those with a score of 8 or less on the AMT referred onto the Memory or other appropriate service.

The above standards need to be achieved for 3 consecutive months in order to receive the associated CQUIN payment and for 100% achievement of the priority.

The approach taken within the acute inpatient areas was to employ an auditor with the responsibility to visit each adult acute inpatient area (excluding maternity). To improve patient care new documentation was introduced to ensure that clinicians were supported in the assessment and ongoing management of these patients and with further clinical support from a dedicated Matron with a

lead for dementia, the auditor was able to capture the required data necessary to show provider compliance with this target and a close working relationship between the Memory Service and the Wards was developed. The Memory service link has been an important element in improving the care these patients receive and along with the Matron has had a positive impact on the awareness and education of dementia care in the hospital setting.

The acute inpatient audit was commenced in July 2012, but for the first month the data collected was used purely to evaluate the audit tool and data collection processes. Once finalised the audit was then fully completed for 5 consecutive months with the Provider meeting the standard of 90% by September 2012. This standard was consistently exceeded from September 2012 through to December 2012, meeting the requirement to have three consecutive months above 90% for each element. The table below shows the percentages achieved over the life of the full audit from August to December 2012.



This priority has made a real difference to patient care and the organisation has shown successful compliance with the audit standards as required. The Memory service has noted that this has certainly helped to raise the profile of dementia detection and treatment with the numbers of referral increasing. There is a need to continue with this progress to ensure that the quality of assessments continue to improve, so that the correct patients are accessing specialist services as required.

3.1.7 Improving Record Keeping

Audit of Patient Records	**Achieved**
Monthly review of nursing records via Productive Ward audit	**Achieved**
Other organisational wide audits such as Mortality will report on quality of record keeping based on a standardised tool	**Partially Achieved (1 of 2)**

Over the last 12 months much progress has been made with regards to improving the record keeping within the Trust, with the primary focus being on the inpatient setting.

In order to support improved record keeping, nursing documentation has been fully reviewed and the Trust now has generic documents in use on all acute general wards; including risk assessments; nursing assessments and care plans, all of which follow the patients through their hospital journey. The new documentation replaces the ward specific assessments and care plans which previously required staff to undertake a full readmission of the patient on transfer to a ward. All documents in use have been subject to regular reviews and are updated in line with user comments.

The new documentation has received positive feedback from both the ward staff and the Trusts Health Records Committee; in relation to its simplicity and its ability to reduce the volume of paperwork to be completed; which in turn has reduced the time required by staff to complete the documentation. In turn this has allowed the Trust to see an improvement in record keeping of the nursing staff. The new documentation was also praised by an external assessor and has been shared with the Department of Health as an example of good practice.

Following a workshop held in the Autumn of 2011; attended by a range of clinical and non-clinical staff from across the organisation, an approved set of record keeping standards and a guidance document on Best Practice in Clinical Record Keeping was produced; which as well as providing support for education and training, also provided agreed standards to allow the Trust to undertake regular audits.

The Trust has also continued to see the progression of its Integrated Systems Information System (ISIS) project which supports further improvements in record keeping as it is rolled out and expanded across the organisation.

Last year the Trust set three priority measurements in order to monitor this priority, and the following information provides details of the Trusts performance against these measures:

KPI 1: Audit of Patients Records

The first audit of patient records was undertaken by medical staff of all grades during August – November 2012. The audit was supported by the Quality Team and the Associate Director of Medical Education. The results of the audit have been shared with medical staff in various forums as well as the Trust's Health Records Committee to ensure lessons are learnt and as an organisation we continue to strive to improve our standards of record keeping.

Overall the results for the audit showed that of the fourteen record keeping standards audited, five of the standards fell below the required compliance level. It is felt that three of these standards will be improved by the implementation of the electronic records; whilst the other two standards relate purely to the individual practice of medical staff. The results have been shared and regular education sessions with Junior Doctors on principles of good record keeping continue to be undertaken.

The second audit was undertaken during February 2013 by a group of inter-professional learning students who undertook an audit to assess compliance with the Organisations Standards for Record Keeping; which resulted in a score of 82.6% compliance. The result of

this work is due to be presented to the July 2013 meeting of the Trusts Health Records Committee.

KPI 2: Monthly Reviews of Nursing Records via Productive Ward Audit

Monthly reviews have been undertaken against compliance with the nursing records via the Productive Ward Audits, the results of which are published monthly via the Trusts Quality Report. An independent audit by a group of Healthcare Students was also undertaken during the year, the results of which have been shared with senior staff.

Monthly reviews of nursing documentation have been undertaken against the revised Productive Ward audit. These results are published monthly via the Trusts Quality Report. The annual compliance for 2012/13 was 87% which just falls short of the 90% target. However the data does include results from the beginning of the year prior to any of the improvement measures being implemented.

KPI 3: Other Organisational wide audits such as Mortality will report on quality of record keeping based on a standardised tool

The Trust committed to undertake two other organisational audits as part of this priority, unfortunately only one was undertaken that specifically looked the quality of record keeping, this was undertaken in relation to the quality of information provided in discharge summaries.

The audit was reviewed by both senior Clinical Staff and Commissioners as part of the Trust's Clinical Quality Review Process. The discharge summary audit showed that overall the Trust was compliant against the standards set; with only 1 area scoring just under the target compliance rate. It was felt that compliance with this standard was low due to the standardised electronic discharge summaries not providing adequate space to record the required data. This information has been fed in to the ISIS project to be considered as an area of improvement as part of the ongoing work in relation to electronic records.

The Isle of Wight NHS Trust will maintain a programme to review and audit documentation and record keeping standards to ensure the continual quality assurance of both written and electronic patient record systems.

3.1.8 Reduction in 28 Day Readmissions in Mental Health

Audit of Patient Records	**Achieved**

During 2012/13 Mental Health Services continued to carefully monitor readmission rates and further work was undertaken to understand which patients are readmitted and why. Guidance for reporting performance against this indicator has been reviewed. It was agreed that patients admitted under Section 136 for assessment under the Mental Health Act and crisis assessment admissions should be removed from data reports.

Changes to the data reporting process during 2012/13 means we are unable to make robust comparison with readmissions figures from the previous year (see chart below). It is apparent from the available data that the required reduction in 28 day readmissions has unfortunately not been achieved. However, regular audit during the year has led to greater understanding of the issues related to readmission and informed plans for improvement. Work undertaken around discharge planning, together with the ongoing reorganisation of Community Mental Health Services and implementation of a whole system approach is expected to result in reduction in readmissions in the future. Although this is no longer a Quality Account priority the service will continue to carefully monitor and analyse readmissions.

Readmission rates 2011/12

KPI Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Readmission rate to in-patient services within 28 days %	15%	16%	5%	12%	7%	21%	17%	13%	13%	14%	10%	23%	14%
Readmission rate to in-patient services within 0 – 59 days %	26%	21%	10%	15%	4%	10%	22%	19%	20%	15%	10%	31%	17%
Readmission rate to in-patient services within 0 – 89 days %	33%	24%	12%	15%	9%	10%	24%	25%	20%	17%	18%	34%	20%

Readmissions excluding CAB Readmissions 2012/13

KPI Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Readmission rate to in-patient services within 28 days %	17%	16%	17%	17%	10%	11%	0%	15%	25%	6%	13%	15%	13%
Readmission rate to in-patient services within 0 – 59 days %	17%	20%	19%	17%	14%	22%	6%	17%	32%	6%	15%	21%	17%
Readmission rate to in-patient services within 0 – 89 days %	17%	20%	25%	19%	14%	27%	9%	19%	32%	8%	21%	25%	20%

A quarterly review of readmissions has been undertaken by the Modern Matron to identify readmission reasons and trends. Analysis of data has identified that the majority of readmissions were for people with Emotionally Unstable Personality Disorder. It is important to note current guidance suggests that prolonged admission periods are contra-indicated for this patient group. It is therefore seen to be more appropriate that people with these conditions may have shorter, repeated admissions.

Inpatient services and community services have been working together to align treatment approaches and improve communication to ensure that discharged service users needs are met. Weekly meetings attended by Ward, Home Treatment and Community Managers have been set up to allow discussions regarding treatment plans for individual patients and ensure appropriate contingency plans are in place. Further work to address the re-admission rate will focus on appropriate discharge planning including:

- Wellness Recovery Action Plan (WRAP).
- CPA and standard care plan.
- Realistic contingency plans agreed with patient.

Wellness Recovery Action Plan (WRAP) was created by Mary Ellen Copeland, author, educator and mental health recovery advocate in the USA. Mary Ellen describes WRAP as:

"a tool that can aid an individual's recovery and its underpinning principles support the recovery approach. WRAP is a systematic way of monitoring wellness, times of being less well and times when experiences are uncomfortable and distressing. It also includes details of how an individual would like others to support them at these different times."

Quarterly audits have been undertaken throughout 2012/13 to establish and monitor the number of patients who have WRAP plans and agreed contingency plans in place and an improvement target will be agreed locally with Commissioners.

Community Mental Health Services are undergoing a period of re-organisation and changes to services include the provision of evidence based care to all service users. Delivery of services will support a recovery model. The Mental Health Foundation describes recovery as *"care focused on supporting recovery and building the resilience of people with mental health problems, not just on treating or managing their symptoms"*. Recovery emphasises that, while people may not have full control over their symptoms, they can have full control over their lives. Locally it is recognised that successfully encouraging a patient to develop a WRAP and agreeing realistic contingency plans with the patient, carer and involved professionals is key to successfully managing crises and may avoid the need for readmission to hospital.

Work continues in the ward environment to ensure that all patients have the opportunity to begin to develop their own WRAP plans in supportive group environments. Whilst not all patients take up this opportunity, the recovery approach is the cornerstone of the therapeutic environment in ward areas. This initiative links through to other group based interventions in community settings, to which patients can be introduced during their inpatient stay, or whilst supported by the Home Treatment Team.

As community teams reorganise along treatment pathways for different diagnostic pathways, then recovery plans will underpin the interventions available to people. This priority will not be carried over into the 2013 Quality Account, but work will continue and quality performance elements monitored via the Directorate's quality meetings.

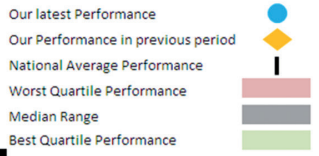
3.1.9 Further Performance Information – Quality Indicators

The following table provides an overview of the Trust performance against a core set of indicators set by the Department of Health and Monitor.

The information has been taken from the Health and Social Care Information Centre (HSCIC). Although the Isle of Wight NHS Trust cannot confirm with any certainty that this information is incorrect, the Performance Information Team have highlighted that there are a number of cases where the information is out of date and there are a number of examples where the data is not consolidated for the full year, leading to instances where the information reported contains only one month/ quarter. Therefore, further work has been undertaken to support this information, where possible, please refer to the last two columns in the table.



Quality Accounts 2012/13 - Isle of Wight NHS Trust



		Data from Health & Social Care Information Centre - Indicator Portal								Local Data Update	
Ref	Indicator Description	Period	Latest Performance	Previous Performance	National Target	National Worst	National Best	National Average	Performance	Period	Performance
1	Summary Hospital-level Mortality Indicator (SHMI)	Oct 11 - Sep 12	**1.06**	1.08	n/a	1.21	0.68	1.00		n/a	**n/a**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- During the past 12 months Isle of Wight NHS Trust has continued to improve its mortality position for which it had previously been identified as a national outlier in 2011. The Isle of Wight NHS Trust intends to take the following actions to improve this indicator and so the quality of its services:- Continuing to build on its Mortality Action plan to further drive through improvements in clinical care and in the quality of its clinical coding. Developments in how clinical teams are utilising the Dr Foster tool will help to identify areas to improve clinical practice and enhanced use of benchmarking data for clinical specialities will further continue to provide areas where the organisation can improve its care.											
2	The % of patient admissions with palliative care coding	Oct 11 - Sep 12	**1.70**	1.50	n/a	0.00	3.20	1.07		n/a	**n/a**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- During the past 12 months the Isle of Wight NHS Trust has continued to improve the depth of clinical coding of all activity, in particular ensuring palliative care and other co-morbidities are appropriately documented and coded. The Isle of Wight NHS Trust intend to take the following actions to improve this percentage, and so the quality of its services:- All deceased patients are coded based on the information contained within the patients notes as opposed to a discharge summary, this allows clinical coders to more accurately reflect the appropriate clinical codes. There is a plan to code entirely from patients notes in											
3	Patients on Care Programme Approach (CPA) followed up within 7 days of discharge from psychiatric inpatient stay	Q3 2012/13	**98.3%**	92.9%	95.0%	92.5%	100.0%	97.6%		2012/13	**96.3%**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The organisation has exceeded the national target of 95% for 2012/13. The Isle of Wight NHS Trust intends to take the following actions to improve this percentage, and so the quality of its services:- To continue to follow up patients within 7 days of discharge.											
4	Category A telephone calls (Red 1 and Red 2 calls) ; emergency response within 8 minutes	Feb-13	**75.8%**	76.4%	75.0%	69.8%	80.4%	75.1%		2012/13	**76.8%**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The Ambulance Service has exceeded the Red 1 & Red 2 target of 75% and benchmarks well against the national average. The Isle of Wight NHS Trust intends to take the following actions to improve this percentage, and so the quality of its services:- Continue to monitor performance to achieve the required performance standards and to continually improve the quality of its services.											
5	Category A telephone calls (Red 1 and Red 2 calls) ; emergency response within 19 minutes	Feb-13	**97.5%**	97.0%	95.0%	92.3%	98.5%	96.0%		2012/13	**97.4%**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- The Ambulance Service has exceeded the Red 1 & Red 2 target of 75% and benchmarks well against the national average. The Isle of Wight NHS Trust intends to take the following actions to improve this percentage, and so the quality of its services:- Continue to monitor performance to achieve the required performance standards and to continually improve the quality of its services.											
6	Patients with suspected ST elevation myocardial infarction who received an appropriate care bundle	Nov-12	**100.0%**	100.0%	n/a	65.6%	100.0%	77.8%		Feb-13	**67.0%**
The Isle of Wight NHS Trust considers that this data is as described for the following reasons:- Patient numbers relating to this quality indicator are very low (potentially only 1 or 2 patients per month). Performance has remained predominantly at 100% throughout 2012/13. The Isle of Wight NHS Trust has taken the following actions to improve this percentage, and so the quality of its services: The Isle of Wight Ambulance Service are actively monitoring every incident of myocardial infarction retrospectively and addressing any shortfalls in clinician practice at the time. The service are also reiterating to every clinician the elements that make up a care bundle for this condition. It has been found during this exercise that poor documentation of a patient taking own medication is having detrimental effect on this target. Ambulance Clinicians are being encouraged to fully document patients own medication intake during these episodes.											

7	Patients with suspected stroke assessed face to face who received an appropriate care bundle	Nov-12	**100.0%**	100.0%	n/a	91.9%	100.0%	96.0%		Feb-13	**100.0%**

The Isle of Wight NHS Trust considers that this data is as described for the following reasons:-
The Stroke Care Pathway includes early access at the 'front door' in line with the National Stroke Guidelines. The Isle of Wight Ambulance Service sees on average 55 potential Stroke patients each month; a failure of 1 element of 1 care bundle will result in a 2-4 % drop in target. The low reporting figures negatively affect the performance outcome. Over the course of 2012/13 a steady improvement in figures reported has been seen which is due to the diligent clinical support and governance surrounding this condition. This support will continue using randomised inspection of clinical records, observed practice, education, reflection and review.

The Isle of Wight NHS Trust intends to take the following actions to improve this percentage, and so the quality of its services:-
There is an ongoing full local Stroke Implementation programme in place and a significant action plan that will continue to be consistently monitored through the monthly Stroke Operational Steering Group.

8	Admissions to acute wards gatekept by Crisis Resolution Home Treatment Team	Nov-12	**97.2%**	96.7%	95.0%	90.7%	100.0%	98.4%		2012/13	**95.0%**

The Isle of Wight NHS Trust considers that this data is as described for the following reasons:-
That not all Mental Health Act assessments are gatekept by the Home Treatment Team (CRHT) including Section 136s which are instigated by the Police. The data shows a steady improvement in performance and overall performance for 2012/13 is in line with the national target of 95%.

The Isle of Wight NHS Trust intends to take the following actions to improve this percentage, and so the quality of its services, by:-
Developing operation serenity which involves joint working; development of existing good practice; enhancing communication between services and joint crisis assessments with the Police seven days a week.

9	Patient reported outcomes measures for elective procedures - (i) Groin Hernia Surgery.	2010/11	**0.104**	0.113	n/a	-0.020	0.156	0.085		n/a	**n/a**

The Isle of Wight NHS Trust considers that this data is as described for the following reasons:
Participation rates continue to be above the national average due to the robust system in place within the Pre Assessment & Admissions unit, where patients are informed and consulted about completing PROMS data returns. Isle of Wight NHS trust have an internal validation process that facilitates the high number of competed returns which is managed by the PAAU Manager who ensures that completion turnaround times are met within 2 - 4 weeks ahead of best practice.

The Isle of Wight NHS Trust intends to take the following actions to improve this score, and so the quality of its services, by:-
Continuing with the process in place ensuring that all hernia patients continue to participate

10	Patient reported outcomes measures for elective procedures - (iii) Hip Replacement Surgery	2010/11	**0.396**	0.406	n/a	0.176	0.503	0.405		n/a	**n/a**

The Isle of Wight NHS Trust considers that this data is as described for the following reasons:-
We have experienced a reduction in patient participation in comparison to previous performance, it is unclear why Hip is singled out against a high performing Hernia and Knee score, further analysis is required to understand the reduction in participation rates.

The Isle of Wight NHS Trust intends to take the following actions to improve this score, and so the quality of its services:-
1) Undertake an internal review of patient understanding of PROMS reasons for non compliance
2) Work with PROMS to review any alternative communication methods to support an increase in participation
3) Continue to validate patients forms to achieve 100% compliance on each form
4) Utilising the Pre Op Assessment & Hip & Knee school to share information and benefits of PROMS to patients to support the desired increase in participation

11	Patient reported outcomes measures for elective procedures - (iv) Knee Replacement Surgery	2010/11	**0.348**	0.301	n/a	0.176	0.407	0.298		n/a	**n/a**

The Isle of Wight NHS Trust considers that this data is as described for the following reasons:-
Participation rates continue to be above the national average due to the robust system in place within the Pre Assessment & Admissions unit (PAAU); where patients are informed and consulted about completing PROMS data returns. The Isle of Wight NHS Trust has an internal validation process that facilitates the high number of competed returns which is managed by the PAAU Manager who ensures that completion turnaround times are met within 2 - 4 weeks ahead of best practice.

The Isle of Wight NHS Trust intends to take the following actions to improve this score, and so the quality of its services:-
Continuing with the process in place, ensuring that all hernia patients continue to participate.

12	Emergency readmissions to hospital within 28 days of discharge : indirectly standardised percent, 16+ years	2010/11	**9.2%**	8.7%	n/a	22.9%	2.4%	11.4%		2012/13	**9.7%** *

The Isle of Wight NHS Trust considers that this data is as described for the following reasons:-
There has been a small percentage rise in readmissions during 2012/13. The data has been reviewed and broken down by specialities to gain a better understanding of the reasons for this. The rise in medical readmissions seems to be static or dropping and the increase on examination of the data would seem to be around short stay surgical readmissions. This is being reviewed.

The Isle of Wight NHS Trust intends to take the following actions to improve this percentage, and so the quality of its services:-
To review the out of hours provision for follow-up relating to surgical patients to prevent the necessity for short term readmissions.

13	Emergency readmissions to hospital within 28 days of discharge : indirectly standardised percent, <16 years	2010/11	**10.3%**	9.2%	n/a	25.8%	3.5%	10.2%		2012/13	**13.3%** *

The Isle of Wight NHS Trust considers that this data is as described for the following reasons:-
The Trust has an open access policy for a cohort of children who need quick access to the Children's Ward. This cohort may have increased, which would lead to an increase in the percentage of readmissions.

The Isle of Wight NHS Trust intends to take the following actions to improve this percentage, and so the quality of its services:-
To review the management of open access patients.

14	Responsiveness to inpatients' personal needs (Score out of 100)	2011/12	**67.50**	67.30	n/a	56.50	85.00	67.40		2012/13	**66.3**

The Isle of Wight NHS Trust considers that this data is as described for the following reasons - This is made up from 5 composite indicator questions:
Q32 Were you involved as much as you wanted to be in decisions about your care and treatment? 71
Q34 Did you find someone on the hospital staff to talk to about your worries and fears? 53.7
Q36 Were you given enough privacy when discussing your condition or treatment? 85.2
Q56 Did a member of staff tell you about medication side effects to watch for when you went home? 45.8
Q62 Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital 75.6

The Isle of Wight NHS Trust intends to take the following actions to improve this score, and so the quality of its services:-
Developing a corporate action plan to address all elements of the report including the composite questions. Quality reporting is being reviewed to bring in line with the NHS Outcomes Framework 2012/13.

15	Staff who would recommend the trust to their family or friends	2012	**50.0%**	52.0%	n/a	36.0%	94.0%	63.0%		n/a	**n/a**

The Isle of Wight NHS Trust considers that this data is as described for the following reasons:-
The organisation has been going through a period or organisational change during the last 12 months and this had impacted on staff morale; in turn impacting on the performance figures; which are currently below the national average.

The Isle of Wight NHS Trust has taken the following actions to improve this percentage, and so the quality of its services:-
A new monthly staff survey has been developed, that includes the above question, to enable the organisational to obtain information on a more regular basis. Information from these monthly surveys will be analysed and findings reported to the Board to agree key

16	Patient experience of community mental health services	2012	**87.7%**	87.9%	n/a	82.6%	91.8%	86.6%		2013	**86.1%**	**

The Isle of Wight NHS Trust considers that this data is as described for the following reasons:-
Performance has remained consistent and patient experience now forms part of the monitoring undertaken by the Mental Health & Learning Diasbilaities Quality Group and actions taken where necessary to ensure peformance is good.

The Isle of Wight NHS Trust has taken the following actions to improve this percentage, and so the quality of its services:-
Encouraging patients feedback on the quality of services, making feedback mechanisms more accessible. For 2013/14 a patient reported experience measure has been developed as a standard quality outcome measure (agred with Commissioners) and this has been built into the quality monitoring process, through the Mental Health & Learning Disabilities Quality Group meetings.

17	Patients admitted to hospital who were risk assessed for venous thromboembolism	Q3 12/13	**93.9%**	92.1%	90.0%	84.6%	100.0%	94.3%		2012/13	**93.1%**

The Isle of Wight NHS Trust considers that this data is as described for the following reasons:-
Monitoring takes place in real time at ward level, with effective systems and processes in place to ensure this occurs. There is also ongoing monitoring of the rate of compliance. This has enabled the organisation to exceed the national target of 90% for this indicator.

The Isle of Wight NHS Trust has taken the following actions to improve this percentage, and so the quality of its services:-
The Trust has implemented an Electronic Prescribing system; which from August 2013 will be set so that prescribing will not be enabled until the required assessment has been completed; which will ensure the assessment is undertaken every time.

18	The rate per 100,000 bed days of cases of C.Difficile infection that have occurred within the trust amongst patients aged 2 or over	2011/12	**13.90**	19.10	n/a	51.6	0	21.8		2012/13	**11.3**	***

The Isle of Wight NHS Trust considers that this data is as described for the following reasons:-
Healthcare Associated Infection Prevention remains high on the Quality Standards Agenda and the organisation met the target for 2012/13, continuing to make year on year improvement.

The Isle of Wight NHS Trust intends to take the following actions to improve this rate, and so the quality of its services, by developing robust working processes for prescribing, cleanliness and patient flow. This journey will be guided by key learning points developed in root cause analysis programmes, inspection and assurances - this will be challenged through the Infection Control Committee.

19	Patient safety incidents and the % that resulted in severe harm or death (i) Total Incident rate per 100 Admissions	Apr 12 - Sep 12	**12.43**	14.08	n/a	1.37	24.88	7.01		Oct 12 - Mar 13	**13.62**	****

The Isle of Wight NHS Trust considers that this data is as described for the following reasons:-
The information above includes incidents reported across Acute, Mental Health, Ambulance, Prisons & Community services, so the figures will be higher compared to other Trusts and, therefore, the national average. This means the reported figures are not truly comparable for benchmarking purposes.

The Isle of Wight NHS Trust has taken the following actions to improve this rate, and so the quality of its services:-
Staff are trained in appropriate reporting and groups highlighted as less likely to report are targeted to ensure appropriate reporting takes place.

20	Patient safety incidents and the % that resulted in severe harm or death (ii) % Incidents that resulted in severe harm or death	Apr 12 - Sep 12	**2.4%**	3.5%	n/a	0.0%	3.6%	0.7%		Oct 12 - Mar 13	**3.4%**

The Isle of Wight NHS Trust considers that this data is as described for the following reasons:-
The information above includes incidents reported across Acute, Mental Health, Ambulance, Prisons & Community services, so the figures will be higher compared to other Trusts and, therefore, the national average. Therefore, the reported figures are not truly comparable for benchmarking purposes.

The Isle of Wight NHS Trust has taken the following actions to improve this rate, and so the quality of its services:-
Staff are trained in appropriate reporting and groups highlighted as less likely to report are targeted to ensure appropriate reporting takes place.

The source data for this analysis is provided by The Health and Social Care Information Centre (HSCIC) within their Indicator Portal. Please note in order to supplement this information with the latest available data analysis of performance from local data sources has been included where possible.

*It is not possible to replicate the method used for standardisation to our local data, therefore the difference between local data and HSCIC standardised data in 2010/11 has been applied to 2012/13 local data in order to make this comparable. This may mean there may be a small variance between these figures and the final HSCIC figures for 12/13 when they are published.

**As there is no detailed guidance on how the HSCIC calculate the number of bed days, the rate for 12/13 has been calculated using the actual number of cases by the number of bed days used by HSCIC in 11/12. This is likely to mean that the actual rate from HSCIC will be lower when published.

***As there is no detailed guidance on how the HSCIC derive the number of Admissions, the rate for Oct to Mar 12/13 has been calculated using the actual number of Admissions used by HSCIC for Apr – Sep 12/13. This may mean the actual rate from HSCIC may be slightly different when published.

3.1.10 Section on Healthcare Associated Infections (HCAI)

The Isle of Wight NHS Trust has continued to focus on HCAI as a quality indicator for 2012/13 alongside the ethos of harm free care. The main focus for the year has been the Acute Hospital with intense scrutiny of compliance to training and cleanliness via the Nursing Dashboard on a monthly basis. The overall trends in HCAI have been monitored and reported in the monthly Quality Report, and Quarterly Directorate Performance Report.

KPI Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Clostridium difficile cases (NHS Trust only)	0	4	0	0	4	1	1	0	1	1	1	0
MRSA bacteraemia (NHS Trust only)	0	1	0	0	0	1	0	0	0	0	0	0
MSSA bacteraemia (NHS Trust only)	0	0	0	0	0	1	1	1	2	0	0	0
E. Coli bacteraemia (whole system)	2	3	7	8	3	8	10	6	9	7	3	8

Methicillin Resistant Staphylococcus Aureus (MRSA)

The Trust was allocated a target of 1 MRSA Bacteraemia case for 2012/13, however the target was breached and there was an increase in cases to 2. The first detected case presented in quarter 1 and the second at the end of Quarter 2. An in-depth multi-professional investigation and root cause analysis was conducted for both cases and whilst the first case would appear to have been unavoidable due to the complex medical presentation of the patient; the second case identified the importance of timely investigations, such as blood cultures; the need to access specialist support such as liaison nurses for patients with challenging behaviours and the importance of cross agency communication in relation to the infection status of patients. All Clinical Directorates participated in the review and no further MRSA Bacteraemia's have been reported since September 2012.

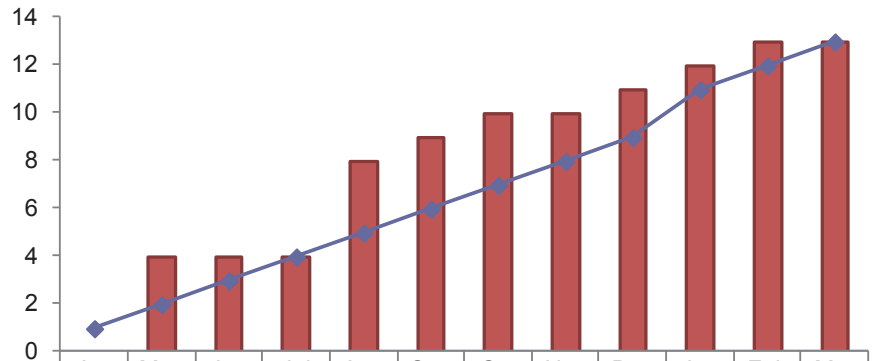
MRSA	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Acute Target	1	0	0	0	0	0	0	0	0	0	0	0	1
Actual	0	1	0	0	0	1	0	0	0	0	0	0	2

Clostridium Difficile Infection (CDI)

In comparison to 2011/12 the Isle of Wight NHS Trust reduced cases of CDI by three. However, the Trust was unable to better the annual target of thirteen cases, which was the final number of cases reported for 2012/13.

A root cause analyses was undertaken on each case; which led to a heighten focus on source isolation and multi-professional collaborative planning of terminal cleaning and reallocation of patients. The Infection Prevention and Control Team have also introduced new standard operating procedures around the use of Chlorine Wipes for the decontamination of commodes used with CDI cases (in line with National Best Practice Guidance). The environmental and cleanliness audits have continued; although it has been acknowledged that the scrutiny of these and related action plans needs to be more robust. The whole Acute Hospital successfully responded to the potential breach in trajectory that it was presented with in January 2013 and there were no further cases in the final quarter of the year. The annual breakdown of cumulative performance is outlined in the graph below:

Acute Target - Acute Acquired Cases (Cumulative)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Acute (Mainland)	0	0	0	0	0	0	0	0	0	0	0	0
Acute	0	4	4	4	8	9	10	10	11	12	13	13
Acute Target	1	2	3	4	5	6	7	8	9	11	12	13

3.1.11 Complaints and Compliments

During 2012/13 reporting of complaints data has continued to be part of the Performance Report to Board and the monthly Quality Report that is reviewed at the Quality & Clinical Performance Committee, as well as reported at various other Committees as part of performance reports. During the year 333 formal complaints were received by the Isle of Wight NHS Trust, an increase on the 2011/12 total of 299.

The main areas of concern raised within the complaints received included:

- Clinical care – concerns about diagnosis / treatment.
- Nursing care – quality of basic nursing care provided.
- Appointment delays / cancellations in outpatients.
- Communication – failure to communicate / lack of information provided.
- Staff attitude.

The total number of complaints received during 2012/13, per month, is outlined in the table below:

KPI Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2012/13 numbers of complaints logged within the NHS COMPLAINTS Procedure	19	34	24	31	26	27	40	35	23	23	33	18	333
2012/13 numbers of Patient Experience (PALS) CONCERNS	79	100	91	86	76	73	65	61	36	69	43	68	847

All complaints received by the Isle of Wight NHS Trust are investigated and reviewed directly with the staff involved, with lessons learnt developed and shared with the wider clinical area. The following positive outcomes and actions have been identified following the review of a selection of complaints in order to prevent similar situations occurring:

- Urology consent form has been reviewed to enable patients to be given a copy to take home.
- Process of providing copies of clinic letters in line with national guidelines has been reviewed to ensure patients are given this option.
- Information literature has been reviewed and has been located to a more prominent and accessible position for patients and carers.
- A system has been introduced on the ward to ensure that senior staff are available to meet with relatives at a dedicated time to discuss any concerns / queries that relatives may have about the care and treatment of patients.

The numbers of compliments about Isle of Wight NHS Trust services continue to exceed complaints with on average 8 compliments for every one formal complaint received, see table below:

KPI Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2012/13 Number of Compliments	219	190	187	154	239	191	191	212	320	260	205	193	2,561

Work is also underway to improve current processes to ensure that complaints are responded to as close to the patient as possible and this work will continue into 2013/14.

3.1.12 Learning from Serious Incidents/Never Events

Serious incidents are defined as an incident that occurred in relation to NHS-funded services and care, which resulted in one or more of the following:

- Unexpected or avoidable severe harm to one or more patients, staff, visitors or members of the public.
- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public.
- Any Never Event. All never events are defined as a serious incident, even those that do not result in severe harm or death.
- A scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services.
- Allegations or incidents of abuse.
- Allegation against a healthcare or non healthcare professional.
- Loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

The Isle of Wight NHS Trust has a responsibility to ensure there are systematic measures in place to protect patients and learn from incidents so as to minimise the risk of them happening again.

Since the appointment of the Quality Managers in the Acute and Planned Directorates (temporary arrangements for Community Health Directorate) there has been an improvement in how we share the learning from Serious Incidents that Require Investigation (SIRI).

Following a SIRI investigation, the learning is extracted from the evidence gathered and, where applicable, an action plan is developed to reduce the risk of a similar situation occurring again (learning from mistakes). The action plan is appropriately shared with relevant senior staff and the overall process monitored by the Quality and Clinical Performance Committee.

Examples of where learning has occurred and actions taken to reduce the risk of re-occurrence are outlined below:

Incident	Recommendation	Change in Practice
Lack of Equipment on discharge	Ensure equipment in place before admission of patient to community bed	The TOC discharge checklist has been reviewed to ensure it includes all equipment required
Misconnected epidural	Ensure the epidural management policy is updated and reviewed, including epidural chart, according to "best practice for the management of epidural in hospital settings 2011" to prevent a recurrence	The epidural chart was updated (October 2012). This now requires 2 signatories for connection to patient to reduce the risk of a similar situation occurring again. Report shared with relevant theatre staff
Patient Fall	Preventative actions should be taken to reduce the risk of falls when patient identified as being at risk	Non-slip socks now available on ward for any patient assessed as being at risk of falls. Also, extra sensor alarms now available in Equipment Library for use when any patient considered at risk of falls

3.1.13 Patient Feedback

The Department of Health published the implementation guidance on the NHS Friends and Family Test on 4 October 2012. The Friends and Family Test aims to provide a simple, headline metric which, when combined with follow-up questions, can be used to drive cultural change and continuous improvements in the Quality of the care received by NHS patients. The question to be asked is:

'How likely are you to recommend our <ward/A&E Department> to friends and family if they needed similar care or treatment?'

The patients that must be surveyed are all adult acute inpatients (staying at least one night in hospital) and all adult in-patients who have attended Accident & Emergency and left without being admitted to hospital or assessed in a Medical Assessment Unit. All patients in these groups should be given the opportunity to respond. Patients must be surveyed at or within 48 hours of discharge / attendance. Current exceptions to this are: day cases, maternity service users, outpatients and patients under 16 years old.

The Isle of Wight NHS Trust prepared for this new initiative during the last quarter of 2012/13, followed by implementation on 1 April 2013. This initiative will form an important element in obtaining patient feedback during 2013/14.

The Isle of Wight NHS Trust values feedback from patients; carers and relatives and is keen to build on work undertaken during 2012/13. Feedback obtained during the last year has supported the Trust in the decision making process for agreeing the new quality priorities, this is evidenced within section 2 of this Quality Account; Key Priorities for Improvement 2013/14.

3.1.14 Workforce

There has been much workforce related activity over the past twelve months, supporting the organisation's drive to deliver quality services for all its patients. This has included:

- Proactive management of sickness absence.
- Ensuring staff receive an annual Appraisal / Professional Development Plan.
- Review of staff survey to identify key areas where improvement can be made.
- Engagement with staff via the 'Big Discussion' and taking action on feedback received.
- Increase in the use of Volunteers – to improve the experience for all patients. This has also included the successful Volunteer Project, which led on the recruitment of a higher number of Volunteers; development of appropriate policies and specific Volunteer role profiles.

For further information; see the section on workforce, in the Isle of Wight NHS Trust's Annual Report.

3.1.15 Section on Equality & Diversity

In November 2011 the NHS Equality and Diversity Council launched the Equality Delivery System (EDS); a framework it has developed to assist NHS organisations complies with equality legislation.

Goal	Rating	
1. Better health outcomes for all	Developing	Engagement and involvement with a limited range of people with differing needs
2. Improved patient access and experience	Developing	Engagement and involvement with a limited range of people with differing needs
3. Empowered, engaged and well-supported staff	Achieving	Engagement and involvement with a good range different of people with differing needs
4. Inclusive leadership at all levels	Developing	Engagement and involvement with a limited range of people with differing needs

The Trust's baseline assessment against the four EDS goals was carried out in 2011 and has recently been updated. The assessment has involved gathering evidence such as reports, surveys and complaints and working with patients and service users to help us arrive at an initial assessment.

This initial assessment has helped us develop our Equality Objectives which can be found at http://195.217.160.2/index.asp?record=2049

3.2 Statements provided by Commissioning PCT, Healthwatch Overview & Scrutiny Committee and Patient' Council

Commissioner Statement in response to the Provider Quality Account 2012/2013

Isle of Wight Clinical Commissioning Group (CCG) welcomed the opportunity to participate in the governance 'sign-off' process and provide a statement in response to the presented Quality Account.

The Quality Account was widely shared with representatives of the Clinical Commissioning Group; Clinical Executives, Heads of Commissioning, and members of the CCG's Quality and Patient Safety Committee for their comments.

Early feedback on the Quality Account was, that as a 'public facing' document it should be easier to read in terms of the language used and reference to such tools as the Hospital Standardised Mortality Ratio, Standardised Hospital Mortality Index and European Pressure Ulcer Advisory Panel four stage grading tool. These examples were referred to without any indication or explanation as to what they were. For the Quality Account next year, it may be helpful during development of the account, to involve patient and or public representatives.

This year the Quality Account appears to focus predominantly on acute services; the opportunity to promote the broad range of community services delivered by the Trust through a specific priority appears to have been missed. However, the key priorities identified by the Trust are considered to be right and it is acknowledged that there will be some overlap across community services, particularly for pressure ulcers, where the CCG has concerns about the high number of pressure ulcers reported.

In light of the Francis report it is pleasing to note the priority on communication. Earlier interaction with patients and the public will help to identify experiences of Trust services, particularly as it is noted that the number of complaints and concerns has increased.

The Patient Experience event held by the Trust, to which the CCG was invited, is commended as a way forward.

The Provider has demonstrated quality improvement in the priorities it set out in last year's Quality Account and has chosen to continue to drive up quality in some of these areas in the coming year, for example 'prevention and management of pressure ulcers'.

It is disappointing to note the under-achievement of some Commissioning for Quality Incentive Schemes (CQUINS); the CCG feels that there have been a number of missed opportunities by which the Trust could have demonstrated quality improvements. It is hoped that in 2013/14 the Trust will embrace the CQUIN schemes agreed between themselves and the CCG to the benefit of patient experience, patient safety and clinical effectiveness.

Quality Account priorities, together with CQUINS and other quality outcomes in contracts, will continue to be monitored in detail by Commissioners, as part of the performance management of the Provider through monthly Clinical Quality Review Meetings and Contract Review Meetings.

Last year the CCG suggested the inclusion of the outcomes and learning from the review of serious incidents and 'Never Events' and more detail of organisational learning as a result of investigating complaints; the CCG notes this suggestion was taken on board by the Trust.

Overall, Isle of Wight Clinical Commissioning Group would commend the Quality Report as a fair reflection of the Provider's positive achievement across the quality agenda and the high level of commitment and effort across a diverse organisation to constantly improve the quality of services provided.

Statement from the Chair of the Board of Healthwatch IW

The Isle of Wight LINk has now handed over to Healthwatch Isle of Wight to take on the role of consumer champion for the island's health and care services.

In the past year, the LINk has worked on issues around late night hospital discharge to residential care homes, adult community mental health services, ran a pilot community information service in GP surgeries and liaised with the Trust on a variety of privacy and dignity issues. LINk also started a project looking into mental health support for children and young people which Healthwatch IW has completed and is due to launch on 4th July. Some of the findings tie in directly to the quality account priorities of 12/13. It is disappointing that none of this work is reflected.

Healthwatch Isle of Wight supports the 4 priorities identified in the Quality account for this year – areas which clearly need to be addressed in order to drive up quality of care at the IW NHS Trust. We recognise the need to address those priorities in detail, but feel that this year's quality account is not presented in a way which makes it a document which is easily accessible to the public. We have been getting consistent feedback about quality of care issues at the Trust and will continue to feed this in through the appropriate channels so that action can be taken. We would have welcomed a clear priority around this area.

The Francis report clearly highlighted the need for 'patient feedback including qualitative information to be made available to all stakeholders in as near 'real time' as possible'. We look forward to working with the Trust to make this a reality.

Dominic Crouch
Chair of the Board of Healthwatch IW

Statement by the Chairman of the Isle of Wight Council's Health and Community Wellbeing Scrutiny Panel to the 2013 Quality

The past year has seen major changes introduced to the health service both at national and local level. As from 1 April 2013 we saw the formal start of the IW Clinical Commissioning Group, Healthwatch Isle of Wight and the Isle of Wight Health and Wellbeing Board. In addition the trust continues to work towards foundation trust status.

It is important that the changes within the NHS does not lose sight that these are aimed at empowering patients to make decisions on the choice and control over treatment in the quest to try to establish data management frameworks to monitor facts and figures.

The Health and Community Wellbeing Scrutiny Panel had the opportunity of discussing the content of the quality account at its meeting on 5 June 2013. In addition a number of issues had been raised by members in advance of the meeting where further clarification from the Trust was required. The panel has had a full response to these.

Central to health care is the individual irrespective of which organisation is responsible for identifying, commissioning or delivering this need. Whilst the panel is pleased with the improvements identified within the quality account it is concerned that the number of complaints and concerns are rising. The views of individuals should not be overlooked and are as important, if not more so, than the inspections undertaken by the Care Quality Commission.

The implications of the Francis inquiry, and the recommendations arising from this, will need to be taken into account and reflected in the Trust's approach to ensuring that the standard of care, treatment and behaviour is of the highest standard.

The panel is re-assured that the Trust's priorities will continue to contribute to its vision and values. The introduction of Board Assurance Walkrounds is a welcome initiative.

Over the past year the Panel has benefited from the regular attendance of the Chief Executive and other senior staff at its meetings. This has enabled members to keep abreast of latest health issues and also assisted with a more detailed debate on waiting times for blood tests and night time discharge of patients. The involvement of representatives from the Trust in the panel's work is greatly appreciated. This demonstrates the positive close working relationship that exists between the Council and the Trust but still recognising that scrutiny can act as a critical friend.

There is a need for the Quality Account to be looked at in terms of it being a public document. The Panel therefore suggest that the Trust should review the style of next year's document to ensure that it encourages increased public and service user understanding and engagement. It is also important to demonstrate the performance of the Trust is compared with that in other areas.

The role of Healthwatch Isle of Wight in representing the views of patients, service users and public interests will continue to be important in helping to identify progress being made with the stated priorities contained in this document. The Panel will work in partnership with Healthwatch Isle of Wight to avoid duplication of effort and help take a wider overview of service delivery.

Councillor Ivor Warlow
Chairman of the Isle of Wight Council's Health and Community Wellbeing Scrutiny Panel

20 June 2013

Statement by the Chairman of the Patient's Council

As can be imagined the Patient Council has had a busy year supporting the move to Foundation Trust and in the development of quality services for Island residents and visitors. Our role includes reviewing plans, participating in service improvement groups and monitoring services. This we undertake with presentations to the Council and visits to services. Our views and recommendations are made known directly to the Trust Board on which we are represented.

We welcome the opportunity to comment on the Quality Account. The Isle of Wight NHS Trust is to be commended on the improvements demonstrated in this Quality Account, and we congratulate the Trust on the progress being made. We make specific comment as listed below:

- We welcome the establishment of the direct helicopter link to the mainland and note that already it has been beneficial to a number of patients.

- The success of the Trust in dealing with increasing winter pressures and emergency admissions is to be commended. The Trust must continue to work closely with partner agencies and organisations to ensure that services outside the direct control of the Trust are resilient and meet set quality standards.

- The developments and improvements in discharge planning including the Home from Hospital team and the low level of emergency readmissions are good news. The Trust must continue to work with partners to identify gaps in the patient pathway which might lead to unnecessary readmissions.

- The development of services in the hospital and community, for example the Hip and Knee School, which support patients in their recovery are welcome and the Patient Council would urge the Trust to continue to ensure that issues affecting patients, such as nutrition, are addressed thus enabling patients to recoup their strength and recover more quickly.

- We would encourage the Trust's services to ensure that patients are put in touch with appropriate support groups. In a small Island community like ours this can be vital to a patients ongoing care, support and recovery.

The Patient Council, consisting as it does of the 'customers of the service' is very aware of the fine services that the Trust delivers, but at the same time will not let complacency creep in. The Council will monitor and comment as appropriate upon the service that we receive. The Patient Council congratulates Isle of Wight NHS Trust on its many achievements during 2012/13 and, recognising the challenges ahead, looks forward to working with the Trust and wider NHS over the coming year.

Mike Carr
Chair, Patient Council

3.3 Statement of Directors' Responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the above legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010(as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;

- the performance information reported in the Quality Account is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and

- the Quality Account has been prepared in accordance with Department of Health Guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board
NB: sign and date in any colour ink except black



Date *28 June 2013*
Danny Fisher,
Chairman, Isle of Wight NHS Trust



Date *28 June 2013*
Karen Baker,
Chief Executive, Isle of Wight NHS Trust

3.4 Changes made to the final version of the Quality Account

- Trend lines added to pressure ulcer data in section 3.1.2.
- Reference to work being undertaken on Francis Review in section 2.2.6.
- Reference to working with Healthwatch and other key stakeholders to drive improving communication in section 2.1.4.
- Addition of baseline data in relation to the improving communication key performance indicators in section 2.1.4.
- The addition of RAG ratings for each of the 2012/13 priorities to enable easier review of performance section 3.1.1 to 3.1.8.
- Updated information relating to CQUIN performance in section 2.2.6.

3.5 How to Provide Feedback on the Account

This important document sets out how the Isle of Wight NHS Trust continues to improve the quality of the services we provide.

Your Views on Quality

We welcome your views and suggestions on our Quality Priorities for 2013/14 set out in Part 2 of this Quality Account.

We welcome feedback at any time on our Quality Account. This can be sent to the Quality Team; Isle of Wight NHS Trust, St. Mary's Hospital, Parkhurst Road, Newport, Isle of Wight, PO30 5TG or emailed to quality@iow.nhs.uk.

You can read more about the national requirements for Quality Accounts on the NHS Choices or Department of Health websites.

You can download a copy of this Quality Account from www.iow.nhs.uk (Publications section) or www.nhs.uk.



APPENDIX 1

Stakeholders engaged in the development of the Quality Account

Executive Director of Nursing & Workforce and Director of Infection Prevention & Control

Chief Executive

Deputy Director of Nursing

Business and Projects Manager – Quality and Clinical Standards Directorate

Health and Community Wellbeing Scrutiny Panel

Patient's Council

Commissioners

Patients; Carers and relatives

Various members of staff – via survey questionnaire

Voluntary Sector Colleagues

Councillors

Communication Colleagues

Media Colleagues

Quality Manager

Head of Communications

Communications Assistant

Communications Consultant

Audit Committee Members

Quality & Clinical Performance Committee Members

Non Executive Directors (as members of relevant Committees)

Head of Governance and Assurance

Practice Development Co-ordinators

Quality Assurance Lead

Medical Director

Information Officer

Assistant Director for Information Management & Technology

Performance Information Department

Business Co-ordinator to the Clinical Directorates

Equality and Diversity Lead

Clinical Nurse Specialist for Nutrition and Tissue Viability

Infection Prevention and Control Team

Team Leader /Senior Clinician – Community CAMHS

Office Manager – Community CAMHS

Lead Research & Development Officer

Business and Performance Manager – Community Health Directorate

Business Co-ordinator – Acute Clinical Directorate

Service Manager – Mental Health & Learning Disabilities / Memory Service

Learning Disability Liaison Nurse

APPENDIX 2

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF ISLE OF WIGHT NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the Audit Commission to perform an independent assurance engagement in respect of Isle of Wight NHS Trust's Quality Account for the year ended 31 March 2013 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 ("the Act"). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the following indicators:

- Percentage of patient safety incidents that resulted in severe harm or death (page 43); and
- Percentage of patients readmitted within 28 days (page 42).

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the Audit Commission on 25 March 2013 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2012 to June 2013;
- papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;
- feedback from the Commissioners dated 27 June 2013;
- feedback from Local Healthwatch dated 27 June 2013;
- the trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 26 June 2013;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated April 2013;
- the latest national staff survey dated 28 February 2013;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 13 May 2013;
- the annual governance statement dated 5 June 2013;
- Care Quality Commission quality and risk profiles dated 31 May 2013;
- the results of the Payment by Results coding review dated January 2013; and
- the Trust's annual report dated 5 June 2013.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Isle of Wight NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Isle of Wight NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selections of different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Isle of Wight NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out the Guidance.

Ernst & Young LLP

Ernst & Young LLP
Reading
28 June 2013